AmeriHealth Caritas VIP Care

Observation Services

Reimbursement Policy ID: RPC.0103.MIDS

Recent review date: 01/2026

Next review date: 02/2026

AmeriHealth Caritas VIP Care reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas VIP Care may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses reimbursement limits of observation services provided in a hospital setting and professional fees which are billed separately. A patient may be admitted directly to observation status; observation status may also be assigned to patients who present to the emergency department and then require treatment or monitoring before a decision is made concerning their admission or discharge.

Exceptions

Scheduled procedures or treatments that require a hospital stay of less than twenty-four (24) hours are considered outpatient procedures, not observation services; similarly, routine stays after outpatient surgery are considered recovery room extensions and are not observation services.

Reimbursement Guidelines

Facilities are reimbursed based on the number of hours of observation billed following same day emergency services, outpatient diagnostic services, or hospital clinic visit. The date of service is the date the order for observation is written.

Observation Services

G0378 - Hospital observation service, per hour

- Ancillary and diagnostic services provided during the period of observation are reimbursable separately.

G0379 – Direct admission of patient for hospital observation care

- This code is not reimbursable if not submitted on the same date as of service as G0378.

Services not reimbursable as observation services include, but are not limited to:

- Outpatient blood or chemotherapy administration;
- Lack of, or delay in, patient transportation;
- Provision of a medical exam for members who do not require skilled medical or nursing services;
- Routine preparation prior to, and recovery following, diagnostic testing;
- Routine recovery and post-operative care following ambulatory surgery;
- Observation while the member is in routine recovery and post-operative care status.
- Services provided for the convenience of the physician, member or member's family;
- Services provided while awaiting member transfer to another facility and observation or inpatient criteria are no longer met;
- Services provided when an overnight stay is planned prior to diagnostic testing and observation criteria are not met;
- General standing orders following outpatient surgery that should be billed as recovery room services;
- Services that would normally require inpatient stay;
- Services following an uncomplicated treatment or procedure;
- Services provided concurrently with chemotherapy;
- Services provided when an inpatient is discharged to observation status;
- Services that are not reasonable and necessary for the care of the member.

Discharge or Admit to Inpatient

Observation status ends when all clinical or medical interventions have been completed. A physician may order the patient be discharged home or admitted as an inpatient. An order for observation services is not considered valid as an order for inpatient level of care. A separate admit order for inpatient services is required. When the member is discharged home, charges for services provided during observation are billed as outpatient level of care.

When a patient receives observation services and is then admitted as an inpatient, the day on which the patient is formally admitted is considered the first inpatient day.

Reimbursement for observation services performed within 3 days of an inpatient admission is subject to the Three-Day Payment Window Policy, RPC.0091.MIDS.

Professional Services
Observation services are reimbursable to the practitioner who orders and is responsible for the patient's care while receiving outpatient observation services. Professional services are reimbursed based on the billed evaluation and management codes for observation including:

- initial (99221 - 99223),
- subsequent (99231 - 99233),
- admit and discharge same day (99234 - 99236), and
- discharge observation (99238 - 99239).

Unrelated E/M services provided on the same date of service (DOS) by the same performing provider are reimbursable only when the service is distinct and unrelated to the observation care. Similarly, all related E/M services, including observation care, provided on the same DOS by the same performing provider are considered integral to an Inpatient E/M admission code. Practitioners providing observation care report an observation E/M code for the professional service(s) on a CMS-1500 Claim Form when the patient is not subsequently admitted as an inpatient on the DOS.

Definitions

Observation
Observation services are defined as the use of a bed and periodic monitoring under the care of a physician by a hospital's nursing or other ancillary staff, which are reasonable and necessary to evaluate an outpatient's condition to determine the need for possible inpatient admission.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. AmeriHealth Caritas VIP Care Provider Manual.
VII. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34552
VIII. Medicare Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0091.MIDS Three-Day Payment Window

Policy History

10/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas VIP Care from Policy History section
01/2023	Template Revised • Revised preamble

	• Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section