

Observation Services

Reimbursement Policy ID: RPC.0103.72AC

Recent review date: 05/2026

Next review date: 02/2027

AmeriHealth Caritas Pennsylvania Community HealthChoices 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 Pennsylvania Community HealthChoices 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

AmeriHealth Caritas Pennsylvania Community Health Choices will pay for clinically appropriate and medically necessary observation services. Facilities are required to bill the number of hours of observation with revenue code 0762. All time must be recorded in whole units. If the final hour of observation is less than 30 minutes, a unit may not be reported. A unit may be reported for 30-60 minutes of observation services.

The date of service is the date the order for observation is written. An acute care general hospital must provide a minimum of 8 hours of observation services to be eligible for reimbursement, unless contracted otherwise.

Observation Services Codes

G0378 - Hospital observation service, per hour

G0379 – Direct admission of patient for hospital observation care

- This code is informational only and is not reimbursable.

All services provided to a member while in a medically appropriate observation stay are included in the case rate payment. Examples include but not limited to:

- Inpatient acute care general hospital services
- 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 post operative recovery 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 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.
- Hospital clinic services
- Hospital physical therapy, occupational therapy and speech therapy provided on any day other than the first calendar day of the period of observation
- Special treatment room services

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 if additional care is medically necessary. 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.0091.05xx.

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 and observation care less than 8 hours (99231 - 99233)
- admit and discharge same day, more than 8 hours (99234-99236)
or (less than 8 hours of care) (99231 - 99233)
- 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 Pennsylvania Provider Manual.
- VII. <https://www.amerihealthcaritaspa.com/pdf/provider/communications/notifications/2024/20241210-observation-billing-reminder-acp-acpchc.pdf>
- VIII. <https://www.law.cornell.edu/regulations/pennsylvania/55-Pa-Code-SS-1150-56b>
- IX. Applicable Pennsylvania Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0091.72AC Three-Day Payment Window Policy

Policy History

05/2026	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas Pennsylvania Community HealthChoices 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