Limit to Charge - OPPS APC Payment Methodology

Last Updated: 11/4/2026 **Last Reviewed:** 11/19/2026 **Originally Effective:** 1/1/2027
Texas Originally Effective: 2/1/2027

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? Yes
If yes, Texas Last Update Effective Date: 2/1/2027 **Policy #: RPM083**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any
Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** DOS on or after 1/1/2027

Purpose of Policy

This policy is intended to promote consistent reimbursement practices and align payment through the Centers for Medicare & Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) methodology while applying our limit to charge standard.

Reimbursement Guidelines

A. Policy Statement

For outpatient facility claims reimbursed under the CMS OPPS with dates of service on or after January 1, 2027 (February 1, 2027 for plans issued in Texas), final reimbursement is limited to the total allowable billed charges associated with services recognized through the applicable APC reimbursement methodology.

When a provider's total submitted billed charges exceed the aggregate APC-considered charges used in determining payment, reimbursement will be limited to the billed charges for APC-considered charges rather than the provider's total billed charges on the entire claim.

B. Calculation of APC-Considered Charges

The total OPPS APC-considered charge amount is determined by summing all eligible charges associated with services recognized under the OPPS APC reimbursement methodology after the application of any applicable:

- Denials
- Exclusions
- Bundling edits
- Packaging provisions
- Multiple procedure reductions
- Status indicator limitations
- Other reimbursement adjustments

C. Other Payable Services

Services eligible for reimbursement under OPPS but not directly reimbursed through APC classification (e.g. laboratory services) will be limited to the charge amount for that service. Each non-APC classified service is evaluated independently. If the billed charge on a non-APC service exceeds what is payable for that service, the excess is not applied to increase the APC-considered charge amount for the APC classified services.

D. Additional Conditions

Nothing in this policy guarantees reimbursement. All claims remain subject to:

- Member benefit plan provisions
- Eligibility requirements
- Medical necessity review
- Coding and billing requirements

- Payment integrity edits
- Applicable reimbursement policies
- Federal and state regulatory requirements
- Other terms and conditions of the member's benefit plan and provider agreement

The terms and conditions of an applicable provider participation agreement, facility agreement, or other negotiated reimbursement contract shall supersede this policy to the extent the contract contains reimbursement provisions that differ from or conflict with this policy. In such circumstances, the contract language will govern reimbursement.

Definitions

Acronyms/Abbreviations

Acronym	Definition
APC	Ambulatory Payment Classification
CMS	Centers for Medicare and Medicaid Services
DOS	Date(s) of Service
OPPS	Outpatient Prospective Payment System
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
TAC	Texas Administrative Code

Definition of Terms

Term	Definition
APC Considered Charge	The charge amount recognized, utilized, or considered by the APC reimbursement methodology when determining payment for outpatient facility services.
Billed Charge	The charge submitted by the provider on the claim.
Bundling Edits	CMS payment rule that combines related outpatient services into a single payment for the combined cost of eligible services and supplies.
Denials	Non-payment of a claim or service.
Exclusions	An item, service, procedure, or claims that is not eligible for coverage or reimbursement.
Multiple Procedure Reductions	CMS reimbursement policy that reduces payment for secondary and subsequent procedures performed on the same patient on the same date of service after the primary procedure is paid in full.
Outpatient Facility Services	Hospital outpatient department or other facility services reimbursed under OPPS APC based methodology.
Packaging Provisions	A CMS OPPS payment policy that includes reimbursement in ancillary and supportive services within the payment for a primary outpatient procedure, making those services not separately payable.
Status Indicators	An OPPS payment designation assigned to a HCPCS/CPT code that indicates whether a service is payable under OPPS and if so, the payment methodology applicable to the service.

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Clinical Editing," Moda Health Reimbursement Policy Manual, RPM002.
C. "Modifier 51 - Multiple Procedure Fee Reductions," Moda Health Reimbursement Policy Manual, RPM022.

D. "Facility Guidelines, General Overview," Moda Health Reimbursement Policy Manual, RPM065.

Resources

1. CMS. "Hospital Outpatient PPS." https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient .
2. CMS. "Integrated Outpatient Code Editor." https://www.cms.gov/medicare/coding-billing/outpatient-code-editor .
3. CMS. "Hospital Outpatient Prospective Payment System (OPPS)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS, § 10.

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
11/19/2026	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2027	Original Effective Date (with or without formal documentation). Policy based on senior management decision, including Claims, Provider Networking & Contracting, & Underwriting.

Attachment 1, Provider Notification Letter for OR, AK, & ID plans

PO Box 40384
Portland, OR 97240

October 29, 2026

<Group Name>
<Address 1>
<Address 2>
<City> <ST> <Zip Code>

Dear <Group Name>,

The purpose of this notification is to clarify how Moda Health calculates the lesser-of reimbursement limitation for outpatient facility services paid under OPPS APC methodology.

This clarification applies to all reimbursement arrangements utilizing the OPPS APC methodology, including OEBB and PEBB business reimbursed under this methodology in accordance with SB 1067.

To date, the Moda Health Commercial Provider Manual and applicable Provider Participation Agreements have not clearly specified the methodology Moda uses to calculate and apply the lesser-of reimbursement limitation for outpatient facility services paid under OPPS APC methodology. Beginning with dates of service on or after 1/1/2027, Moda Health's policy will be to apply the cap at the APC level.

No change is required on behalf of the provider. Please review https://www.modahealth.com/texas/provider/resources/moda-policies/moda-policy-manual for additional policy details.

As always, payment remains subject to member eligibility and benefits, medical necessity, accurate coding and billing, applicable payment edits and policies, regulatory requirements, and the terms of the applicable Provider Participation Agreement.

Thank you for your continued partnership.

Sincerely,
Moda Health

Attachment 2, Provider Notification Letter for TX plans

PO Box 40384
Portland, OR 97240

October 29, 2026

<Group Name>
<Address 1>
<Address 2>
<City> <ST> <Zip Code>

Dear <Group Name>,

The purpose of this notification is to clarify how Moda Health calculates the lesser-of reimbursement limitation for outpatient facility services paid under OPPS APC methodology.

This clarification applies to all reimbursement arrangements utilizing the OPPS APC methodology, including OEBB and PEBB business reimbursed under this methodology in accordance with SB 1067.

To date, the Moda Health Commercial Provider Manual and applicable Provider Participation Agreements have not clearly specified the methodology Moda uses to calculate and apply the lesser-of reimbursement limitation for outpatient facility services paid under OPPS APC methodology. Beginning with dates of service on or after 2/1/2027, Moda Health's policy will be to apply the cap at the APC level.

No change is required on behalf of the provider. Please review https://www.modahealth.com/texas/provider/resources/moda-policies/moda-policy-manual for additional policy details.

As always, payment remains subject to member eligibility and benefits, medical necessity, accurate coding and billing, applicable payment edits and policies, regulatory requirements, and the terms of the applicable Provider Participation Agreement.

Thank you for your continued partnership.

Sincerely,
Moda Health