$166,166.13 FACILITY BILL

When the claim did not match the chart - and the contract controlled the payment.

A self-funded employer plan negotiated the reimbursement rules before an advanced urological procedure. The hospital later submitted $166,166.13 in facility charges. A chart-to-claim audit found a material patient-status discrepancy that directly affected which Medicare methodology applied under the Single Case Agreement.

$166,166.13	$31,510.00	$27,600.00
FACILITY BILL	RECOVERY ROOM CHARGES	AUDITED 4x DRG FACILITY AMOUNT

1 | BEFORE CARE WAS DELIVERED

The plan negotiated the rules first

- The Single Case Agreement covered laparoscopic pyeloplasty, CPT 50544, for the July 28, 2026 episode.
- For an outpatient encounter, facility reimbursement was tied to Medicare OPPS methodology, including comprehensive APC packaging.
- The agreement expressly removed billed charges from the reimbursement calculation.
- Most important: if the encounter converted to inpatient status, the facility methodology switched to 400% of the applicable Medicare MS-DRG, in lieu of the outpatient calculation.

THE CONTRACT LANGUAGE THAT MATTERED

“If the encounter converts to inpatient status, the aggregate Facility payment shall instead equal four hundred percent (400%) of the Medicare payment for the applicable MS-DRG ... in lieu of the outpatient calculation.”

2 | WHAT THE AUDIT FOUND

The UB-04 and the clinical record told different stories

- Claim status: The facility submitted Bill Type 131 - hospital outpatient.
- Clinical record: The postoperative documentation described transfer to the floor, an overnight stay, Post-Op Day 1 care on the floor, and discharge material referring to “inpatient care.”
- Recovery room billing: Revenue Code 0710 appeared on both service dates - 8 units for $18,000 and 14 units for $13,510 - for a total of 22 billed units and $31,510.
- Diagnosis mix: The claim carried Q62.11 with status/device Z-codes and no claim diagnosis identified in the audit as a CC or MCC. The inpatient comparison therefore used MS-DRG 661, the no-CC/MCC kidney/ureter procedure benchmark.

WHY THIS WAS NOT A SMALL CODING DETAIL

Under this agreement, patient status determined the Medicare payment methodology. The outpatient calculation was higher than the inpatient DRG benchmark. The Plan Document also imposed a payment reduction when required pre-certification was not obtained. The status discrepancy therefore had a direct financial consequence.

3 | CONTRACT ENFORCEMENT

Billed charges did not get a vote

- Billed charges were irrelevant. The SCA states that reimbursement is in lieu of - and not calculated by reference to - the providers' billed charges.
- Status conversion was addressed prospectively. If the encounter converted to inpatient status, the facility payment moved to 400% of the applicable MS-DRG.
- Recovery and observation services were included in the episode. Under the inpatient DRG methodology, those facility charges do not create a separate additional payment.
- The SCA did not amend the Plan's governing documents. Any applicable Plan Document pre-certification reduction remained a separate adjudication issue.

4 | FINANCIAL IMPACT

What the contract did to a $166,166.13 facility bill

METRIC	AMOUNT	RESULT
Hospital facility billed charges	**$166,166.13**	Not the reimbursement basis
Audited 400% Medicare MS-DRG 661 facility amount	**$27,600.00**	Contractual inpatient benchmark
Recovery room charges included in billed total	**$31,510.00**	No separate add-on under DRG
Difference: billed charges vs. contractual facility benchmark	**$138,566.13**	**Facility charge exposure avoided**

Note: Professional services remained separately payable under the SCA. The $27,600 figure shown here is the audited facility benchmark. Any Plan Document reduction for failure to obtain required inpatient pre-certification would be applied separately if triggered by the governing plan terms.

5 | WHAT PLAN SPONSORS SHOULD TAKE FROM THIS

Four rules that protected the plan

1. Write the methodology before care

A prospective SCA can remove billed charges from the equation before the claim ever arrives.

2. Include a status-conversion clause

Outpatient-to-inpatient conversion can change the Medicare benchmark dramatically. Address it in writing.

3. Audit the chart against the claim

Do not review the UB-04 in isolation. Patient status, service location and clinical documentation can change reimbursement.

4. Protect the member too

The agreement should make the negotiated payment payment-in-full and prohibit balance billing beyond plan cost-sharing.

BOTTOM LINE

The audit did not "negotiate down" a $166,166 bill. The plan had already negotiated the reimbursement rules. The work was enforcing those rules, matching the claim to the clinical record, and refusing to let chargemaster pricing replace the contract.

RECEIPTS REVIEWED

Single Case Agreement; UB-04 facility claim; postoperative progress note; discharge summary and instructions; governing Plan Document pre-certification provisions. Member identifiers omitted.

This case study describes one plan-specific claim audit. Payment rules vary by contract, plan terms, patient status, locality and date of service. It is not legal or medical advice.