

# ASC Claims Matching: Is Your Facility Losing Revenue?

by Jessica Edmiston, BS, CPC

For years, many of the larger carriers have used a policy called “matching.” Matching is when you code a facility claim accurately according to the documentation, submit the claim; and, if your claim arrives before the professional claim, it is kicked into pending status for the carrier to verify that your claim matches the professional charge. The same holds true with anesthesia claims.

This carrier policy can present two problems for the facility coder. Your codes could be changed to match the professional charges, resulting in down-coding and reduced revenue. The claim may not pay until your money chaser calls and it gets toggled back into adjudication. It’s important to know your carriers’ policies with respect to claims matching and argue your case when codes are changed.

You may think matching claims for the ASC, professional and anesthesia charges should be easy. After all, if the three claims are for the same surgery, why wouldn’t the carriers match the claims to the correct codes? To answer this question, let’s first take a look at the ASC claims process.

## Play the Matching Game

The ASC claims process is understood using this coding scenario: you may code and bill an arthroscopic rotator cuff repair 29827 *Arthroscopy, shoulder, surgical; with rotator cuff repair* with a subacromial decompression 29826 *Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release*, and the anesthesiologist codes and bills an open rotator

cuff repair 01610 *Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla*. The surgeon codes for only the arthroscopic rotator cuff repair. The carrier assumes only one claim is right and that’s usually the surgeon. The documentation supports the facility claim, but you’re reimbursed for only one procedure.

Matching may occur after payment, and if this is the case, you’ll find out with negative balance invoicing. The carrier will state it overpaid and want a refund, which is usually taken out of future payments. Whether the carriers are matching claims on the front end or the back end, it is a policy that can be costly for your facility.

There are ways to avoid down-coding from delayed claims because of matching. Match the facility claims with the professional and anesthesia claims on a daily basis and notify all parties if there is a discrepancy. This may seem like a lot of work; however, it only is if the claims don’t match. A solution is to call for a meeting to discuss possible solutions. Or have the same coder for all three entities: ASC, professional, and anesthesia.

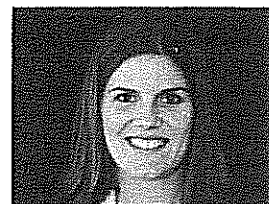
If you plan to appeal a down-coded claim, contact the surgeon’s office and discuss the appeal with the coder or surgeon. When dealing with the surgeon’s office, some administrators prefer that you go through them rather than the coder or surgeon. Both the facility and the surgeon should have coded the surgical case in the same manner if you want to have a successful appeal.

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### When Not to Match

There are times when the claims are not supposed to match. For instance, the surgeon performs an arthroscopic medial meniscectomy and an arthroscopic chondroplasty in the lateral compartment of the knee. The facility should report code 29881 *Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)* while the surgeon would report 29881 as well as a G0289 *Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee* or 29877 *Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)* for the chondro-

plasty, depending on the carrier. National Correct Coding Initiative (NCCI) edits dictate that a facility must not unbundle a chondroplasty from virtually all other arthroscopic knee procedures. However, the surgeon should bill the chondroplasty code if performed in a separate compartment. In this case, the facility and professional claims should not match. To improve compliance and revenue, ensure accurate coding, and avoid claims delay due to matching, code from the operative reports and other documentation. Always involve the administrator, and coordinate codes with the surgeon and anesthesiologist. This will streamline the claims process. When it comes to carrier matching, fight as a team and you will be successful. ■



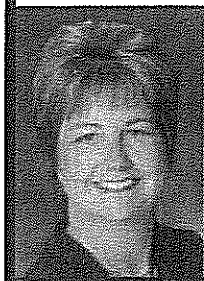
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