USC SCORING METHODOLOGY

INSTRUCTIONS FOR COMPLETION: Listed below are instructions by category on how to transfer individual chart reviews to the USC Monitoring Summary Report. The compilation of this data will determine the "Pass" or "Fail" rate for each encounter reviewed. An encounter is defined as **all services** (CPT codes) for the selected provider on a specific date of service. Per the USC Healthcare Compliance MA-500 policy, providers that score less than 80% on the 10 encounters reviewed in the aggregate must have additional reviews performed. Each service (CPT code) is given a maximum score of 10 points. The basis for assigning points is detailed below.

The overall scoring of points for individual services is as follows:

CPT code	**1-9 points**
Legibility	**1 point**
TOTAL	**10 points**
	Diagnosis, Modifier, Place of Service and Physical Presence Determination are also scored as described below. .
Diagnosis	**If not met, "1-5" point(s) deduction from claim reviewed**
Modifiers	**If not met, "1-5" point(s) deduction from claim reviewed**
Place of Service	**If not met, "5" point deduction from claim reviewed**
Physical Presence	**If not met, "10" points deduction from claim reviewed**

The cumulative score of all encounters reviewed will be added upon completion of the review to determine if the provider attained a passing score. If the 10 encounters contain more than 10 individual services (CPT codes) that are reviewed then the total number of services will be multiplied by 10. The total number of possible points will be multiplied by .80 to determine the passing score (see example below). The total score will be compared against the passing score to determine a pass or fail grade. For example, fifteen (15) individual services (CPT codes) are reviewed. A total of 150 points (10 points x 15 services) is the total possible score; a passing score of 80% is 120 points. The total number of points will be compared against the passing score of 120 to determine if the clinician passed the review.

Components of review are as follows:

Retrospective/Prospective Review: *On the Chart Review Worksheet* identify whether the claim is being reviewed retrospectively or pre-billing (prospectively).

Provider Issues: This category is used to identify errors (if any) in documentation of coding accuracy. Results from these categories are for determination of either Pass or Fail of the individual service. Billing and Abstraction issues are informational only and should not be calculated in the provider's Pass or Fail score.

Medical Record #: Note MR# of patient

Date of Service: Note the actual date of service for the encounter being reviewed.

CPT CODES AND MODIFIERS

CPT Code(s): List billed CPT code and modifiers (if applicable).

Recommended CPT Code(s): List reviewers recommended code(s) and modifier.

Scoring of E/M code accuracy: If the E/M service is one level higher than recommended there should be a 2 point deduction. If the E/M service is greater than 2 levels higher than recommended or assigned the wrong category, there should be a 7 point deduction. Under coding should be assigned a 1 point deduction.

Scoring of Procedures: If the CPT code(s) listed is correct, the service should be scored 9 points. No credit will be assigned for identifying the wrong code even if the code is in the right family/category of codes – deduct "9" points.

Time Based Procedures: If time is not documented in the record, the service should be assigned to the lowest level of service within the CPT code category. In these cases, a score of "7" points should be deducted.

Anesthesia Procedures*:* If the CPT code(s), even if the code is in the right family/category of codes and the Base Units are incorrect, there should be a deduction of 7 points. If the CPT code(s) is correct, but the time listed is incorrect the total point deduction should be 5. However, if the time is clearly documented correctly and the base units listed is incorrect, there should be a deduction of 5 points.

FINAL SCORING: FOUR additional factors will be reviewed prior to assignment of the final score. The three areas of review are:

1. ***Legibility:*** One (1) point will be assigned if there are no legibility issues for the individual claim; illegible claims will be given a 1 deduction. This column is used to track legibility issues for individual providers and trend findings. Auditors should note providers with legibility issues in the summary section and refer the case(s) to the Compliance Liaison or USC Office of Compliance for further review, if indicated.

2. **Diagnosis:** If a diagnosis is incorrectly assigned, "1 -5" point(s) should be deducted from the total score. This should be scored once per service reviewed even if multiple diagnosis issues are identified on an individual service (example of reimbursement effected is when an LCD requires a diagnosis that is billed but not documented).

3. ***Modifiers:*** If a modifier is incorrectly utilized there should be "1-5" point(s) deducted from the total score. This should be scored once per service reviewed even if multiple modifier issues are identified on an individual service (example of reimbursement effected is the improper use of modifiers 25, 57 or 59).

4. **Physical Presence: (select category) P**ass vs. **F**ail—The entire note should be reviewed for adherence to the teaching physician guidelines. After the CPT code accuracy has been determined, if the teaching physician documentation is not adequate to meet the presence requirements deduct the total amount of accumulative points. The entire service will "Fail" if the physical presence component has not been met regardless of the coding accuracy. If the physical presence requirements are met, the service will stand at the original number of points assigned. If physical presence requirements are not met, the service receives an overall score of "0" since lack of documented physical presence is not a billable service. Examples of the physical presence category are listed below.

   Clear (P)
   Co-Signature (F)
   Electronic Signature
   (P) Unclear (F)
   No Documentation (F)

5. ***Place of Service:*** If the place of service is incorrect there should be a deduction of 5 points.

Upon Completion of the Form:
The abstractor must determine whether or not the provider issues are in excess of 21% and require further review and monitoring. Additionally, the auditor will need to denote on each claim reviewed whether or not adjustments should be made to the billing form (see below). The auditor should sign and date the form, discuss findings with the physician, amend (if necessary) findings based on discussion, note areas for future education and have the provider sign and date the Audit Summary form.

Claim Adjustment Needed: Document whether or not a claim adjustment is needed by stating a “yes” or “no” in this column. Reasons for claims adjustment would be any of the following: a change in the billed CPT code, an ICD-9-CM change that impacts reimbursement, a modifier that impacts reimbursement or physical presence is not met. This information will help identify claims that need adjustment.

Comments: The auditor should also evaluate trends in coding practices (i.e., physician with 5 services of over coding by one level) which did not directly result in a failing aggregate score. All trends should be documented on the summary audit form. The information should be discussed with the physician and the compliance liaison