Incentive Programs Offer Aid to Increase Coding Productivity

by Amy L. Gleberman, RHIA

Incentive programs can be a good tool for increasing productivity while maintaining coding quality. Employees who are rewarded for extra production will likely perpetuate higher levels of productivity. High coding productivity can improve a healthcare organization's bottom line by shortening the turnaround time in billing and the revenue-to-cash cycle. Also, coding incentive programs may increase employee retention, which saves the hospital the costs of new employee recruitment.

Two HIM managers have recognized the benefits of rewarding productivity and have developed and implemented successful coding incentive programs in their facilities. This article will share their stories and discuss key components of coding incentive programs. We will also examine the steps involved with developing and implementing an incentive program, and explore the challenges that can be expected with this process.

Proactive Solution For Reducing Accounts Receivable

In July 1998, Claudia Steele, RHIA, CCS, clinical data manager for Christ Hospital and Medical Center in Oak Lawn, IL, wanted to improve accounts receivable before the start of a hospital-wide computer conversion. She anticipated that the computer conversion would hurt coding production due to difficulties with the new computer interface.

Steele asked her staff of 17 full- and part-time coders if they could work extra hours during the computer conversion. The part-time coders were willing to work extra hours during the conversion, but they were not willing to give up their free time for straight pay. Steele decided that paying coders for their production instead of a flat hourly rate would be a good method for securing the commitment she needed to keep the accounts current during the computer conversion.

To participate in the Pay Per Record Program, coders first had to complete their regular hours for the week. Full-time coders had to work 40 hours before they could start earning incentive pay, and part-time coders had to work 20 hours before they could participate. Steele tracked hours by using colored timecards and production sheets to delineate between regular coding hours and pay per record hours, adding that it is a good "check and balance system."

Incentive Pay Rate and Coding Standards

To determine a fair incentive pay rate, Steele took the midpoint of the hourly pay range for coders, then multiplied the mid-point by 1.5 (overtime rate calculation) to get a production rate. She then divided the production rate by department productivity standards that represent three different types of records coded (e.g., inpatient, day surgery, emergency department), to get the pay per record rate for each work type (see Table 1, right).

table 1—formula for calculating production pay rate

(midpoint of hourly salary range x 1.5)/ production standard for a given work type)

Pay Per Record Program:

	Inpatient	Day Surgery	ED Records
Standards (per record)	3 Records/ Hour	8 Records/ Hour	15 Records/ Hour
Coding/ Abstracting	$8.00	$3.00	$1.60
Coding Only	$6.00	$2.25	$1.20
Abstracting Only	$2.00	$0.75	$0.40

Program Guidelines and Components

Participants in the Pay Per Record Program must adhere to specified guidelines. As clinical data manager, Steele is committed to building an accurate data set from ICD-9-CM and CPT-4 codes by ensuring the quality of coded data. Some of the program

guidelines uphold the basic tenets of data quality, like maintaining a minimum of 95 percent coding accuracy, requiring CPT-4 codes on all outpatient records, and E-codes on both inpatient and outpatient records.

A certified coding review specialist monitors the coding quality of the Pay Per Record Program through routine, focused audits on select DRGS and daily random review audits. Error rates are tracked and communicated to the coder. For coders who drop below the 95 percent accuracy requirement, additional education and in-services are provided. Further, an external audit is conducted once a year to verify the quality of inpatient and outpatient coding.

Another guideline states that outlier charts, like charts of $50,000 or above and normal newborn records, are excluded from the incentive program.

"We didn't want to discourage [program participants], so we left the large outlier charts to be coded during the normal course of business," Steele says. Because the original coding standards included these outlier charts, the incentive chart coders "have an extra edge to be able to be more productive," she adds.

Pay Per Record participants are also required to complete a special productivity form to record their daily coding output. To preclude coders from choosing the easiest charts to code to enhance their production pay, inpatient records must be coded in terminal digit order and outpatient records must be coded in alpha order.

Incentive Program Development and Implementation

After Steele developed the incentive program plan, she took it to the director of human resources, who was reluctant to try it because there was no other incentive program in place within the facility. Steele also met with the vice president of finance (VPF) to discuss the viability of her incentive plan.

In her presentation to the VPF, Steele emphasized the financial advantages of placing internal coding staff on an incentive plan over hiring contract coders. In her department, contract coders only did the coding, and then internal staff still had to abstract the charts. Steele estimated that the average contract coder wage was significantly higher than the proposed salary for incentive pay coders.

The VPF found the numbers very encouraging and supported the incentive program plan. Communication about the new program was done via a memo that outlined the plan standards, pay rates, and guidelines. Maximum flexibility was built in, so a coder could choose to participate one week and forgo the program the following week. Participation was voluntary but the coders had to meet the chief requirements of completing regular work hours and maintaining productivity and accuracy standards.

The Pay Per Record Program had noticeable benefits. When accounts receivable increased to almost $30 million during the computer conversion, the HIM department had an effective and cost-efficient strategy for reducing the number of unbilled cases. Another advantage was that the quality monitoring was a standard working procedure for the internal coding staff.

A Strategy For Reducing Backlog and Encouraging Employee Retention

Barbara Dingman, MBA, RHIA, director of medical records/compliance at Medical Center Hospital in Odessa, TX, developed a Coder Production Pay Program in October 1998, following the successful implementation of an at-home transcription production program. Dingman had recently started scanning medical records into an electronic format. She projected that within two years, her coders could work from home if she could improve productivity variations and reduce the department's coding backlog.

Recruitment and retention of certified coders was difficult for Dingman because the hospital is located in a remote area of Texas. There were six coders on staff, and one was planning to leave soon. To increase productivity and maximize the efforts of her small staff without compromising quality, Dingman designed the Coder Production Pay Program.

Structure of the Coder Production Pay Program

Dingman attributes the success of the program to assistance from the director of human resources and a progressive chief financial officer, who championed the Coder Production Pay Program. As compliance officer for her facility, Dingman is quick to stress the integrity of her program. "The coders are paid on the number of charts that they code, and not based on any dollar amount that the hospital might get back as the result of billing," she says. "There is no incentive to upcode or enhance the billing."

A key requirement for participation in the voluntary Coder Production Pay Program is the certified coding specialist credential. Also, coders are required to sign a formal agreement that defines program expectations, addresses fluctuating work hours, and outlines the production standards and pay rates. A sample agreement might read like this:

- I understand that my accuracy rate must be maintained at 97 percent or higher.
- My pay will be determined by the number of charts coded and not by the number of hours worked.
- I understand that there will be times when I will be expected to work more than 80 hours per pay period in order to get the work done when other team members are out.
- I understand that there will also be times when the workload will not require me to work 80 hours in a pay period.
- I understand that, as a production employee, I will receive the same benefit package offered to all employees and will be considered a full-time employee.

To ensure that it met legal requirements, Dingman found that the production pay program needed to include three components. First, a facility needs to guarantee that production coders are paid the minimum hourly wage. The facility also must guarantee an hourly rate for nonproduction activities like auditing charts, special projects, or attending meetings. Finally, the production pay per record rate must be based on meeting the department's coding standards, said Dingman.

Production Standards

In Dingman's department, some coders are paid a straight hourly rate and meet the productivity standards shown in Table 2, below.

Currently, two certified coders with more than one year of service participate in the Coder Production Pay Program. As long as the coders meet the standards shown in Table 3, they are paid for each coded record. If they fall below these standards, they are paid an hourly rate.

Maintaining 97 percent coding accuracy is another program requirement. Coding quality is monitored in various ways, including peer review, random audits, quarterly audits by an independent consultant who provides feedback, and continuing coding education seminars. Finally, the local peer review organization and the Department of Health and Human Services audit charts and offer guidance on correct coding practice.

Implementation And Challenges

The success of the at-home transcription production program made buy-in easier to obtain for the coding production program. To accelerate buy-in, Dingman initiated a two-month trial period of reports issued every two weeks to give the coding staff an idea of how production pay compared to their regular take-home pay. This generated excitement about production pay.

In addition, the certified coders were offered flexible shifts. At the start of the production program, the coding staff was resistant to changing from a rigid hourly schedule to a more fluid one.

"When discharges were down in the hospital or there were not enough available charts to keep the coders busy, they were instructed to go home early because they had already earned their pay for the day," explains Dingman. The coders quickly recognized the value of the production program and the flexibility it offered.

Implementation was not without challenges. The coding staff had to learn that they were no longer hourly employees who could just walk in and take work. At the beginning there was some tension over the supply and demand of charts. When the production coders were out of charts, they were taking charts to code that had not been assembled and analyzed because they were afraid they were not going to make enough money.

"It caused some problems with our work flow in the medical records department, but we solved this by having a coding supervisor allocate work to the production staff after the charts were assembled and analyzed," Dingman says.

Keeping up with coding demands is a challenge for nearly every healthcare facility. Dingman and Steele found ways to elicit higher production from their staffs without compromising employee satisfaction or coding quality. Each program pinpointed essentials for a successful incentive program: voluntary participation; explicit communication about quality standards, program requirements, and pay rates; and a supportive administration. While both programs initially met with mild resistance, the overall outcome has been more than positive.

table 2—productivity standards

Chart Type	Months of Service	Production Standard
Inpatient charts	>3 months >6 months >1 year	2.6 hr or 20/8 hour day 3.0 hr or 22.5/8 hour day 3.7 hr or 28/8 hour day
Ambulatory surgery/observations	>3 months >6 months >1 year	3.7 hr or 28/8 hour day 4.5 hr or 33.7/8 hour day 5.3 hr or 40/8 hour day
Emergency room	>3 months >6 months >1 year	30 hr or 225/8 hour day 40 hr or 300/8 hour day 50 hr or 375/8 hour day

table 3—pay standards

# per hour	1 chart = x minutes	Pay Rate
Inpatient charts at 3.7	16.2	$7.00 per chart
Ambulatory surgery/observations/ one day stay at 5.3	11.3	$3.50 per chart
Emergency room charts at 50	1.2	$0.50

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