Unlocking Revenue: Boosting Reimbursement and CMI Through Strategic "Tier Hunting"

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Abstract

The implementation of "tier hunting", a targeted approach to identifying and capturing accurate tiers in inpatient rehabilitation facilities (IRF's) has proven to be a strategic approach for increasing revenue by ensuring that tiers are accurately documented and coded on the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). Accurate tier designation plays a critical role in appropriate CMG LOS projection and reimbursement and helps reflect an IRF's clinical acuity through Case Mix Index (CMI).

This presentation explores the process of implementing "tier hunting" at a group of facilities, which included educational initiatives targeted at physicians, clinical liaisons, IRFPAI/PPS coordinators, clinical staff, and coding staff, alongside the implementation of the "tier hunting" protocol. The process involved identifying targeted diagnoses that were most frequently missed due to lack of specificity in documentation. The protocol also included educating the IRFPAI Coordinator or PPS Coordinator to identify, track, and collaborate across departments to ensure the correct documentation flow from physician to coding.

While utilizing tools like eRehab, the facilities who implemented the protocol were able to identify and code missing tiers, ultimately leading to improved accuracy in CMG assignment. The results of this initiative were quantified, demonstrating a significant increase in revenue at the participating facilities.

This presentation highlights the protocol's process and the steps taken for implementation at an IRF so that similar approaches can be adopted in other facilities, aiming to improve financial performance through improved documentation.

Introduction

IRF PPS Definitions

Rehabilitation Impairment Categories (RIC)
Diagnoses grouped by the primary reason for intensive rehabilitation.

Case-Mix Groups (CMG)
Classification system used to group patients with similar clinical and utilization resource needs, including primary diagnoses, functional status, age and co-morbidities. Patients are assigned a CMG, each with a unique weight – which helps CMS determine appropriate payment weight under the IRF prospective payment system. This is to reflect the patient complexity and cost of their care.

Comorbidity Tiers Under IRF-PPS
A Medicare system that classifies a patient's comorbidities into Tiers 1,2,3 or no tier (tier 0) to reflect the expected increase in cost and resource use for a patient's rehabilitation stay.
Payment Impact
Higher tier comorbidities signify more complex cases with higher expected resource needs to account for the added cost of treatment.
Tier 1: Highest-cost comorbidities (commonly: renal dialysis and tracheostomy)
Tier 2: Intermediate-cost comorbidities (commonly: dysphagia, C-diff, pseudomonas)
Tier 3: Lower-cost comorbidities (commonly: diabetes with complications, cellulitis, CHF, obesity)
Non-Tiered (Tier 0): Comorbidities that do not have codes grouped in the above categories

Tier Hunting Protocol

Identify all patients currently in hospital without a tier assignment

⇩

Review the BMI of each patient

⇩

Review coded diagnoses- looking specifically for diabetes without complications and unspecified heart failure

⇩

Work with SLP to identify patients who are being treated for dysphagia

⇩

Review chart for supporting documentation of specificity or complications in record

⇩

Query physician if appropriate

⇩

Coordinate coding of correlating ICD-10 codes with coder

Methodology

Benchmark Review
Facility-level operational outcomes were reviewed using *eRehabData* national benchmarks. Analysis revealed that several facilities reported a disproportionately high proportion of **Tier 0 patients** when compared to the national average. This raised concern that patient complexity may not have been fully represented in coding and IRF-PAI processes.

Targeted Chart Reviews
To investigate, targeted chart reviews were performed at facilities identified with elevated Tier 0 proportions. Reviews compared information across:
- Patient records
- Physician documentation
- IRF-PAI submissions

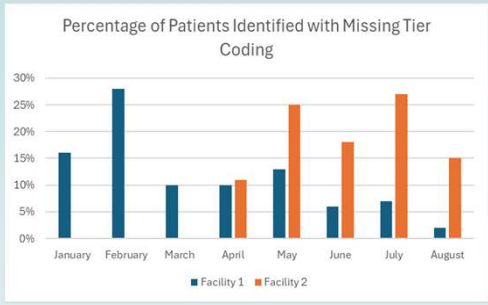
Gap Identification
Findings demonstrated that tier-adjacent diagnoses were often present in the clinical record but lacked the necessary **supporting physician documentation** to qualify as tiered diagnoses. This omission led to:
- **Under-representation of case complexity**
- Reduced **length of stay (LOS)** projections
- Lower **reimbursement rates** under the IRF PPS

Focused Improvement Initiative
In response, a structured initiative was launched to strengthen documentation and coding accuracy. Four diagnoses were identified as priority targets for focused education, monitoring, and process improvement:
- **Dysphagia**
- **Congestive Heart Failure (CHF)**
- **Obesity**
- **Diabetes**

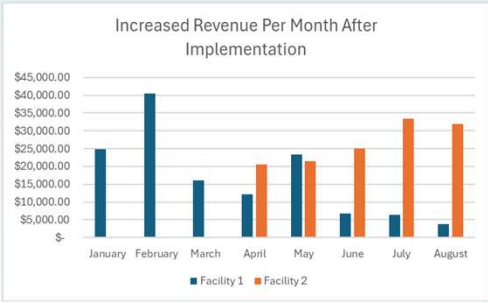
Intervention Process
The improvement initiative followed the following workflow:
- **Chart Review** – Identification of tier-adjacent diagnoses.
- **Physician Collaboration** – Providers completed supporting documentation where clinical evidence was present.
- **Coding Update** – Coders incorporated the validated tiered diagnoses into the patient chart and IRF-PAI.

Diagnosis-Specific Insights
- **Dysphagia:** Frequently identified by SLPs during evaluations and reported in interdisciplinary team (IDT) meetings. With proper physician documentation, this diagnosis could be consistently captured as a tier.
- **CHF:** Commonly documented as *unspecified (Tier 0)*. When physicians specified the type (e.g., systolic vs. diastolic), cases qualified for tier assignment.
- **Obesity:** Many patients' BMI met criteria for obesity class I–III, but physician documentation did not specify class, preventing tier recognition.
- **Diabetes:** Often documented as *without complications (Tier 0)*. Chart reviews frequently revealed clinical evidence (e.g., hyperglycemia, hypoglycemia) to support coding as a tiered diagnosis.

Results



This graph represents the percentage of patients who discharged who had tiers found through the protocol per facility



This graph represents the amount of increased revenue per facility that was gained through the protocol

Conclusion

Hospital #1 achieved a revenue increase of **$133,980** over an eight-month period, while Hospital #2 achieved **$132,297** in just five months. These outcomes highlight the measurable financial and clinical impact of focused education, repetition, and sustained training. At Hospital #1, repeated reinforcement of tier-capture principles led to greater independence by both physicians and coders in accurately identifying comorbidities at the time of admission.
Overall, this initiative—referred to as *"tier hunting"*—proved to be a successful strategy. By improving the precision of Case Mix Group (CMG) assignment, hospitals were able to ensure that the **average length of stay (ALOS)** more appropriately reflected patient complexity. This not only enhanced revenue but also strengthened alignment between clinical acuity and resource utilization. The results demonstrate that systematic education, accurate documentation, and coder-physician collaboration can drive both **quality outcomes** and **financial sustainability** across inpatient rehabilitation facilities.