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Home-Based Primary Care (HBPC) Masterclass: Optimized Management in HBPC to Improve Clinical Outcomes and Reduce Avoidable Costs (Part 1)

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Brad Sirota, CPC, CPMA

11/20/2025

Accreditation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of PeerPoint Medical Education Institute and the Home Centered Care Institute. PeerPoint Medical Education Institute is accredited by the ACCME to provide continuing medical education for physicians. PeerPoint Medical Education Institute designates this educational activity for a maximum of 9.0 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This webinar is worth 1.5 *AMA PRA Category 1 Credits*™

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The following planners, speakers, reviewers or staff have relevant financial relationships to disclose: All presenters, planners, editors, or staff report no relationships to disclose.

Agenda

1. Objectives & Speakers
2. Introduction
3. Congestive Heart Failure
4. Chronic Obstructive Pulmonary Disease
5. Wound Care
6. Minimizing Falls at Home
7. Urgent Visits
8. Q/A
9. How to Access the HCCI Learning Hub™
10. Conclude

Objectives

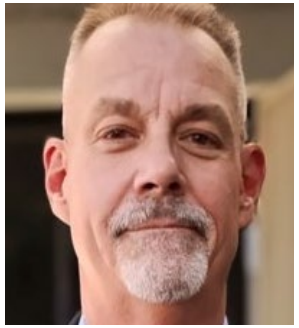
1. Recognize clinical, cost-effective, and patient-centered strategies for managing CHF, COPD, wound care, fall risk, and urgent visits in home-based care settings to improve patient outcomes and reduce avoidable hospitalizations.
2. Identify accurate coding and billing practices related to CHF, COPD, wound care, and fall risk to support compliance and optimize reimbursement.
3. Become familiar with medication recommendations and care planning approaches tailored to medically complex, homebound patients.

Disclaimer: *This webinar is for educational purposes only and does not constitute medical or legal advice. Providers should exercise independent clinical judgment and consult applicable billing guidelines and regulations before implementing any practices discussed.*

Presenters

Paul Chiang, MD

Consultant, HCCI



Brad Sirota, CPC, CPMA

Consultant, HCCI

Introduction

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Opening Discussion

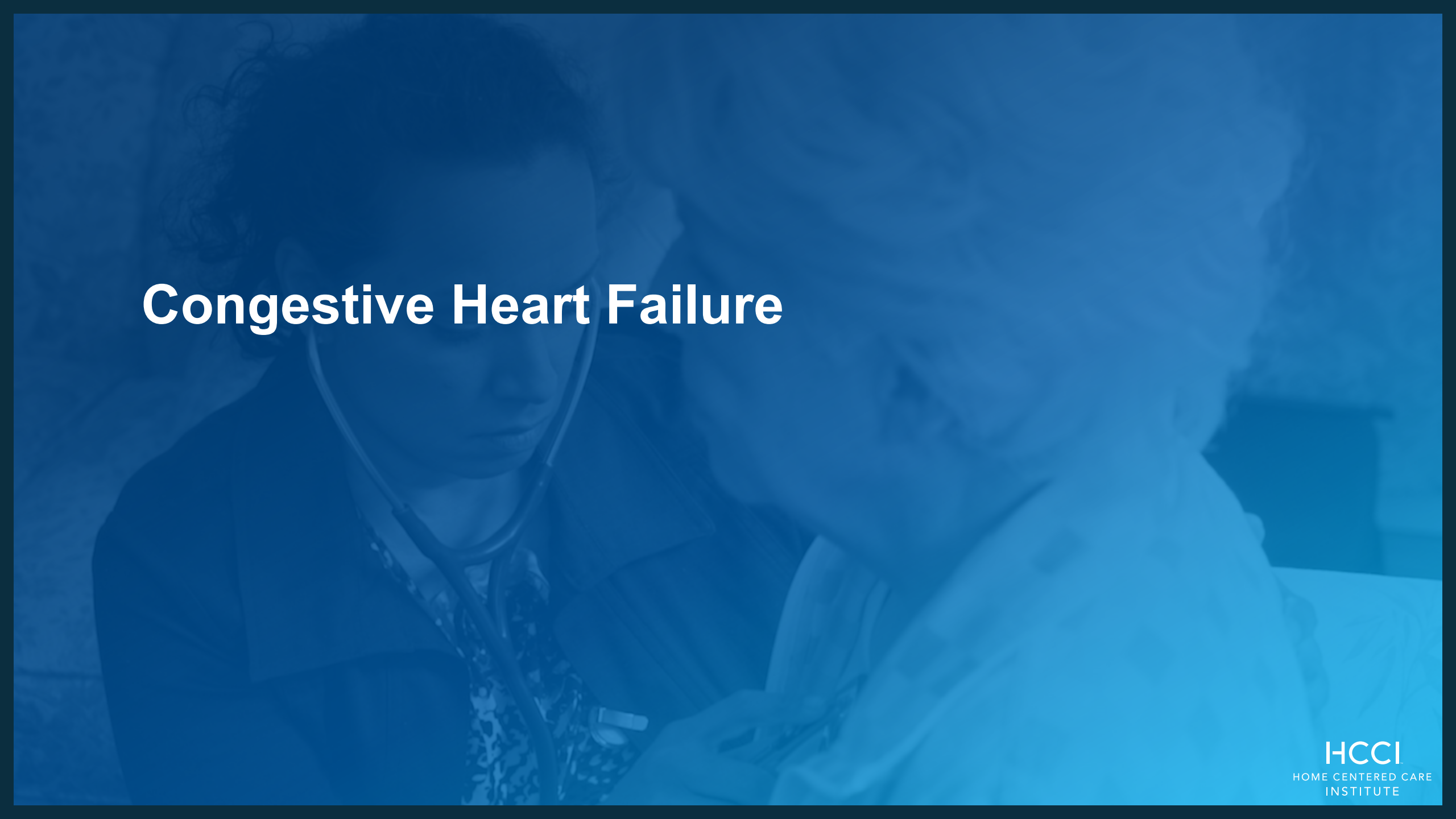
What is your biggest challenge in managing patient care at home?

What strategies have worked well for your team?

Why Optimization Matters in HBPC

- Rising costs of avoidable hospitalizations
- Impact of chronic disease on homebound populations
- Opportunities for proactive, high-value care
- Alignment with value-based care models

Congestive Heart Failure



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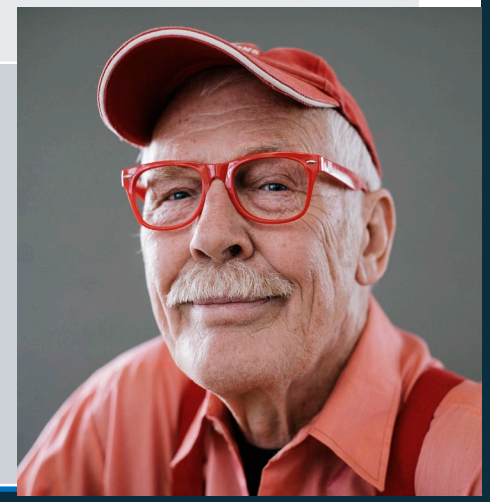
Congestive Heart Failure Case Study

Mr. Jim

Patient Profile					
Age	78	**Gender**	Male	**Insurance**	Medicare + Medicaid
Living Situation	Lives alone in a one-bedroom apartment; daughter visits weekly				
Primary Diagnosis	CHF (NYHA Class III) Hypertension Type 2 Diabetes			Chronic Kidney Disease (Stage 3) Mild cognitive impairment	
Recent Clinical History	Hospitalized 3 weeks ago for acute CHF exacerbation (fluid overload, SOB) Discharged with increased diuretic dose and dietary recommendations No cardiology follow-up scheduled Missed one home health visit due to transportation issues				
Current Status (Home Visit Today)	Weight increased by 5 lbs over past 3 days Mild shortness of breath with exertion Reports fatigue and poor appetite **Medications:** Furosemide, Lisinopril, Metformin, Aspirin Daughter reports he sometimes forgets to take meds No scale at home; relies on visual cues for swelling No advance care planning documented				



Congestive Heart Failure

Recognition

- Leg swelling
- Shortness of breath
- Orthopnea
- Fatigue
- Anorexia, nausea, vomiting
- Increase in abdominal girth or symptoms

Diagnosis

- Physical exam
- Chest x-ray
- Echocardiogram
- Lab

Congestive Heart Failure

Guideline-Based Medication Recommendations

Medication Class	HFrEF	HFmrEF	HFpEF
ARNI/ACEI/ARB	X	X	
BB	X	X	
MRA	X	X	X
SGLT2i	X	X	X

Congestive Heart Failure (HFrEF)

Management Considerations

- Institute salt and fluid restrictions within the patient's goals of care
- Monitor weight; instruct patients to contact provider if weight gain >3 lbs/day or 5 lbs/week
- Ensure patients take medications as prescribed; deprescribe unneeded, harmful medications (example NSAIDs)
- Have patients report increase leg swelling, cough, shortness of breath, loss of appetite/GI symptoms, and/or trouble sleeping flat
- Elevate legs, when possible; use compression stockings

Congestive Heart Failure

Cost Reduction Strategies

- Early intervention for weight gain or dyspnea
- Use of telemonitoring or nurse check-ins
- Post-discharge follow-up within 48–72 hours
- Coordination with cardiology and palliative care

Congestive Heart Failure

All CHF is reported with ICD-10 category 150.xx

Code First:

- Heart failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8)
- Heart failure due to hypertension (I11.0)
- Heart failure due to hypertension with chronic kidney disease (I13.-)
- Heart failure following surgery (I97.13-)
- Obstetric surgery and procedures (O75.4)
- Rheumatic heart failure (I09.81)

Congestive Heart Failure

Coding Notes

Subtypes of CHF in ICD-10 Coding

- Left Ventricular (150.1)
- HF**r**EF Systolic (I50.2)
- HF**p**EF Diastolic (I50.3)
- Combined Systolic/Diastolic (I50.4)
- Other (150.8)
- Unspecified (150.9) ***Not Recommended***

Acuity

- Unspecified "0"
- Acute "1"
- Chronic "2"
- Acute on Chronic "3"

Congestive Heart Failure

Coding Pitfalls

1. **Coding an Excludes 1** (two conditions that can't be reported at the same time or can't occur at the same time in a single patient). *Systolic* or *Diastolic* cannot be coded with *Combined*

2. Reporting an *Unspecified* diagnosis code

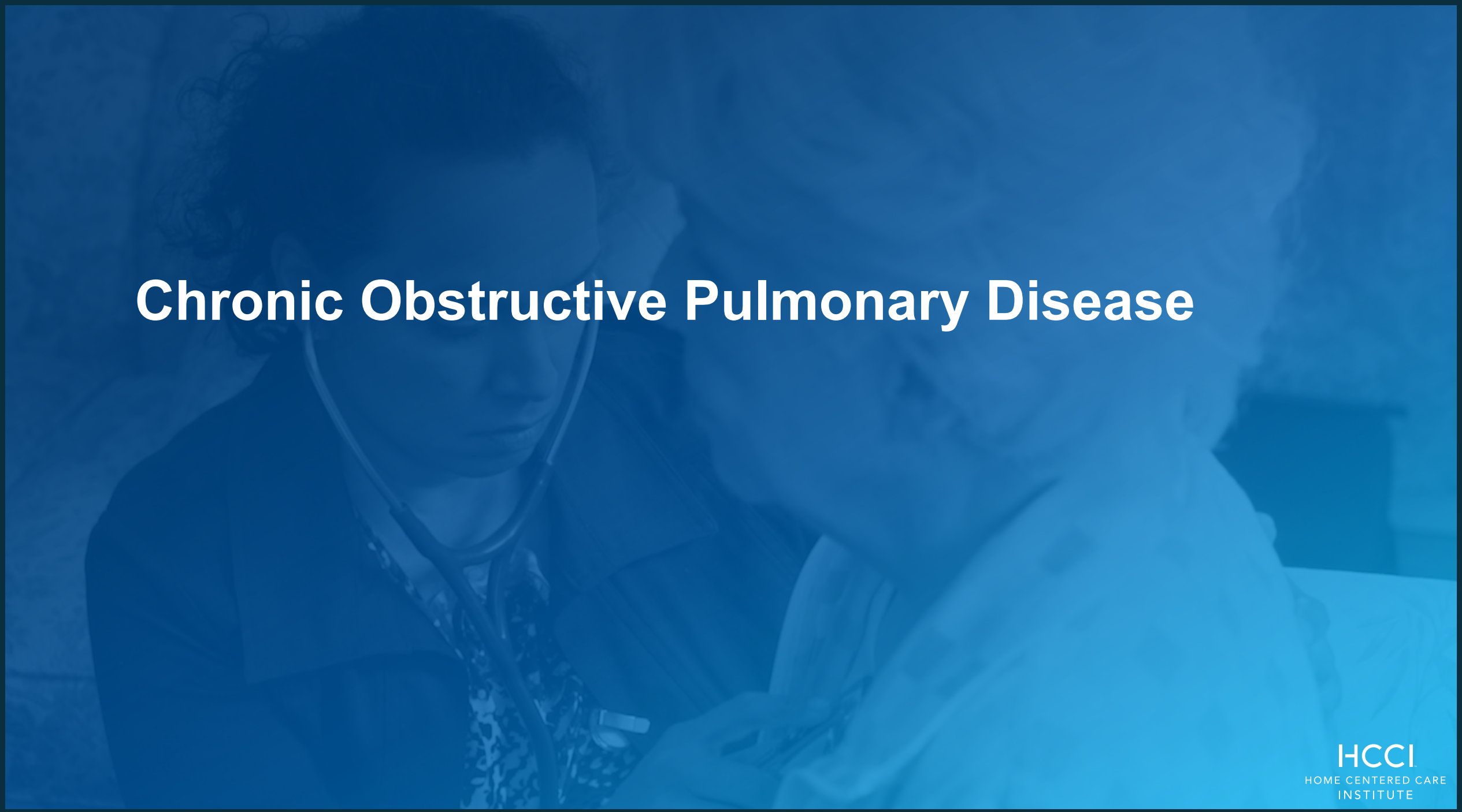
Poll Time! Let's Hear From You

Which of the following interventions has been most effective in your practice for managing patients with CHF?

- ❑ *Optimizing diuretic therapy*
- ❑ *Regular telehealth check-ins*
- ❑ *Home-based medication reconciliation*
- ❑ *Early identification of weight changes*
- ❑ *I'm not sure / Not applicable*

Open Discussion: ***What strategies have you found most helpful in preventing CHF-related hospitalizations in the home setting?***

Chronic Obstructive Pulmonary Disease



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Chronic Obstructive Pulmonary Disease Case Study

Ms. Dorothy

Patient Profile					
Age	74	**Gender**	Female	**Insurance**	Medicare Advantage
Living Situation	Lives with adult daughter who works full-time				
Primary Diagnosis	COPD (J44.1 – with exacerbation)				
Comorbidities	Anxiety, Osteoarthritis, Tobacco Dependency, & GERD				

Recent Clinical History	Current Status (Home Visit Today)
• Two ED visits in the past 6 months for COPD exacerbations • Prescribed albuterol and tiotropium; uses nebulizer occasionally • No pulmonary rehab referral • Reports frequent shortness of breath and fear of leaving home • No formal action plan in place	• SOB with minimal exertion • Worsening cough & increased sputum production • Inhaler technique incorrect • Oxygen saturation: 91% on room air • Anxiety symptoms worsening • Daughter unaware of exacerbation signs or action plan • No recent spirometry or specialist follow-up

Chronic Obstructive Pulmonary Disease

Pharmacological Therapy of COPD

- **Group A:** Low risk, less symptoms, 0-1 moderate or severe exacerbation history
  - LAMA plus prn SABA, or LABA plus prn SAMA-SABA/SABA, or prn SAMA-SABA/SABA
- **Group B:** Low risk, more symptoms, 0-1 moderate or severe exacerbation history
  - LABA+LAMA (single inhaler may improve compliance), and SABA prn
- **Group E:** High risk, less symptoms ≥ 2 moderate exacerbation or ≥ 1 severe exacerbation leading to hospitalization
  - LABA+LAMA plus prn SABA. LAMA+LABA+ICS plus prn SABA if eosinophil count > 300

Chronic Obstructive Pulmonary Disease

Clinical Best Practices

- Smoking cessation counseling
- Inhaler technique checks
- Pulmonary rehab referrals
- Oxygen therapy monitoring

Management Goals

- Improve symptoms
- Maintain/improve exercise tolerance
- Prevent exacerbation
- Reduce mortality

CPTs for Smoking & Tobacco Cessation Counseling

99407: Intensive > 10 minutes
99406: Intermediate 3 to 10 minutes

- Medicare covers **two *cessation attempts**** per year

  **A structured, time-limited course of treatment designed to help a patient quit tobacco use.*
- Each cessation attempt can include a maximum of four intermediate (99406) or intensive (99407) counseling sessions
  - Up to 8 sessions total per year
- Cost-sharing and prior authorization have been waived
- Robust documentation is required
  - Implementation date, type of tobacco, quantity, duration, previous attempts – methods used, impact on health, finances, available resources and the patient's willingness to quit

CPT 94664

Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device

- Medicare covers four sessions per year; once per day with a maximum of two in a six-month period
- Documentation is **not** time based; documentation should clearly indicate the service provided - *Demonstration of and/or evaluation of...*
- Can be coded with evaluation & management services with a 25/59 modifier.

Example:

99350-25: House call visit – high medical decision making

94664-59: Demonstration and/or evaluation of...

Chronic Obstructive Pulmonary Disease

Cost Reduction Strategies

- Exacerbation action plans
- Home pulse oximetry
- Early treatment of infections/exacerbations
- Minimize unnecessary ED visits

Chronic Obstructive Pulmonary Disease

General Coding Notes

- CCM for chronic management
- BHI if anxiety/depression present
- Document exacerbation frequency and interventions

All COPD is reported with J44.x

1. **J44.0 COPD** *with* Acute Lower Respiratory Tract Infection
2. **J44.1 COPD** *with* Acute Exacerbation
3. **J44.9 COPD** Unspecified

Chronic Obstructive Pulmonary Disease

ICD-10 Chapter Guidelines for COPD & Respiratory Conditions

Code Z77.22	Exposure to environmental tobacco smoke
Code Z87.891	History of tobacco dependence
Code Z57.31	Occupational exposure to environmental tobacco smoke
Codes from category F17.-	Tobacco dependence
Code Z72.0	Tobacco use

Chronic Obstructive Pulmonary Disease

***An acute exacerbation is not the same as a new infection superimposed on the chronic condition, though an infection can trigger the exacerbation.* (I.C.10. a.1.)**

Example 1: "Patient with COPD and Pneumonia…"

- J44.0 (COPD with Acute Lower Respiratory Tract Infection)
- J18.9 (Pneumonia Unspecified)

Example 2: "Patient with COPD exacerbation and Pneumonia…"

- J44.0 (COPD with Acute Lower Respiratory Tract Infection)
- J44.1 (COPD with Acute Exacerbation)
- J18.9 (Pneumonia Unspecified)

Documentation Tip: include clinical findings and the cause of COPD exacerbation

- **Avoid using these terms:** "*rule out...*" or "*suspected...*"

Poll Time! Let's Hear From You

Do you use action plans for COPD exacerbations?

- ❑ *Yes, for all COPD patients*
- ❑ *Only for high-risk patients*
- ❑ *No, but we're planning to*
- ❑ *No, not currently*

Open Discussion: ***What's your biggest barrier to managing COPD at home?***

Wound Care

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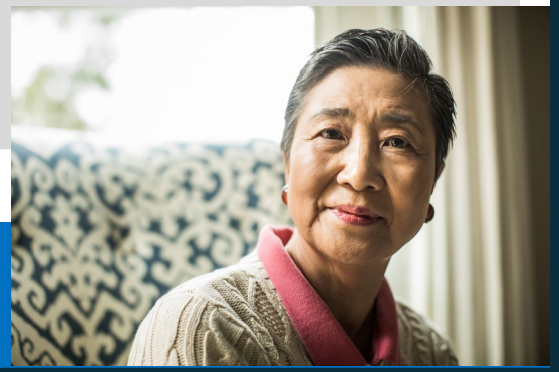
Wound Care Case Study

Ms. Christine

Patient Profile					
Age	82	**Gender**	Female	**Insurance**	Medicare
Living Situation	Lives with daughter, limited mobility due to stroke				
Primary Diagnosis	Stage 2 pressure ulcer on right heel				
Comorbidities	Type 2 Diabetes, peripheral vascular disease, history of stroke				

Recent Clinical History	Current Status (Home Visit Today)
• Ulcer present for 3 weeks, worsening drainage • No wound care specialist involved • Home health nurse visits twice weekly • Daughter performs dressing changes but lacks training • No documentation of wound measurements or staging	• Ulcer with moderate serous drainage, mild erythema • No signs of systemic infection • Dressing not appropriate for wound type • No offloading device in use • No wound care plan documented in EMR



Wound Care

Stages of Pressure Injuries

Stage	Description
Stage I	An observable pressure noted when compared to another body area. The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.
Stage II	Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to (but not through) the underlying fascia. The ulcer presents clinically as a deep crater with or without undermining adjacent tissue.
Stage III	Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to (but not through) the underlying fascia. The ulcer presents clinically as a deep crater with or without undermining adjacent tissue.
Stage IV	Full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bone or supporting structures (e.g., tendon, joint capsule).

Wound Care

Clinical Best Practices

- Pressure injury prevention (turning schedules, cushions)
- Accurate staging and documentation
- Appropriate dressing selection
- Infection control and referral when needed

Assessment

- Location
- Stage
- Dimension (L x W x D) undermining / tunneling
- Exudate
- Odor
- Wound base

Wound Care

Plan of Care Considerations

- Pressure offloading
- Cleanse with wound cleanser
- Hydrocolloid or foam dressing
- Adequate protein intake
- Change dressing 2-3 days & PRN dressing change if saturation is ≥75%

Dressing Types to Keep in Stock:

- Cleansers
- Alginates
- Collagens
- Composites
- Contact layers
- Foams
- Gauze (impregnated or wrapping)
- Hydrocolloids
- Hydrogels
- Transparent films
- Tapes
- Lotions, ointments & creams
- Moisturizers
- Collagenase Santyl
- Regranex
- Antifungal agents

Wound Care

Cost Reduction Strategies

- Preventing hospitalizations for infected wounds
- Use of home health wound care nurses
- Telehealth wound assessments
- Early detection of deterioration

Wound Care

Coding & Billing

- ICD-10: L89.xxx is used for all pressure ulcers
- The final character specifies the stage
- Example: Sacral Pressure Ulcer:

  L89.150 Unstageable*

  L89.151 Stage 1

  L89.152 Stage 2

  L89.153 Stage 3

  L89.154 Stage 4

  L89.156 Pressure induced deep tissue damage

  L89.159 Stage unspecified*

Wound Care

Selective Debridement CPT Codes

- All Selective Debridement CPT codes are reported by area in 20 sq cm increments
- CPT selection is determined by the deepest tissue layer debrided

Skin (Epidermis/Dermis)	97597 + 97598 x 8
Subcutaneous tissue	11042 + 11045 x 12
Muscle and/or fascia	11043 + 11046 x 10
Bone	11044 + 11047 x 10

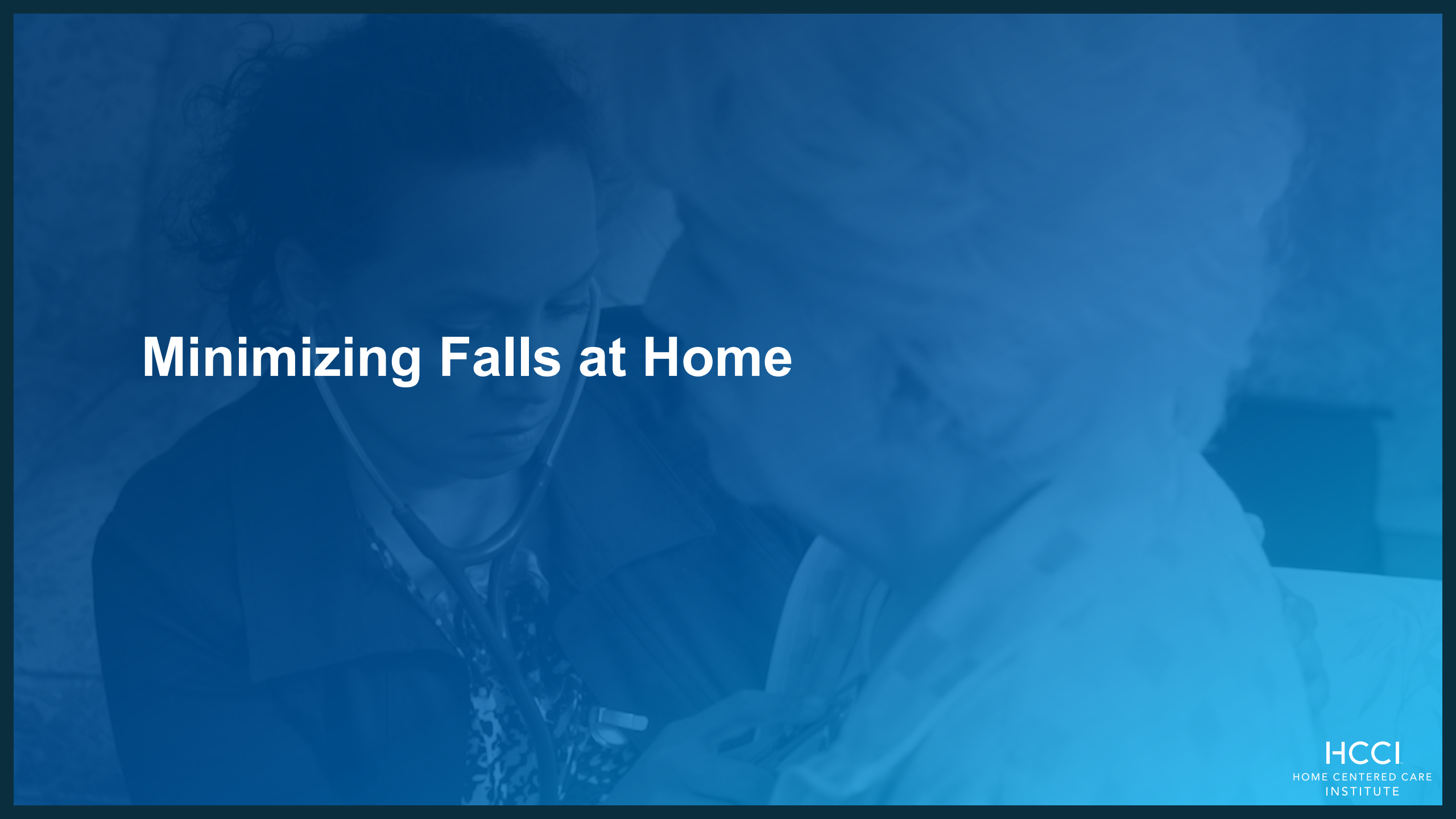
Poll Time! Let's Hear From You

What is your biggest challenge in managing wound care in the home setting?

- ❑ *Timely access to wound supplies*
- ❑ *Coordinating with wound care specialists*
- ❑ *Ensuring consistent documentation for billing*
- ❑ *Patient or caregiver adherence to wound protocols*
- ❑ *I'm not sure / Not applicable*

Open Discussion: ***How do you address barriers to effective wound care in the home?***

Minimizing Falls at Home



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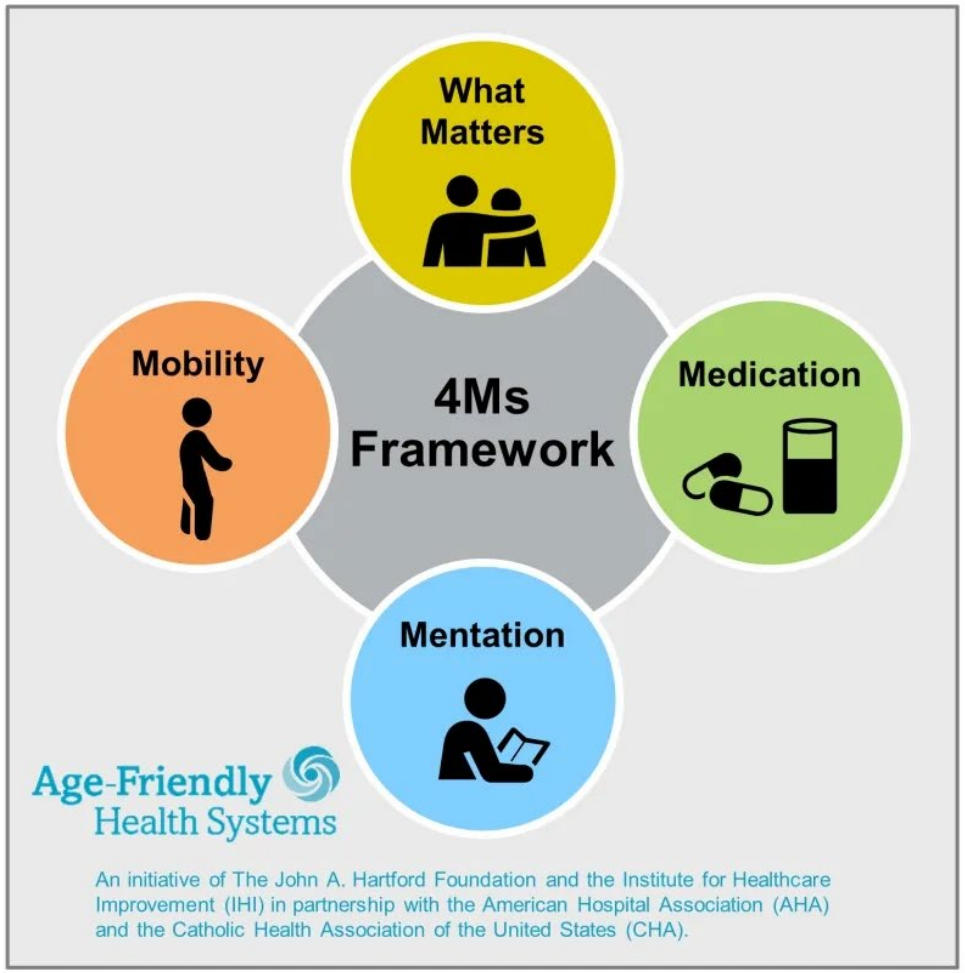
Minimizing Falls at Home Case Study

Mr. Tom

Patient Profile					
Age	80	**Gender**	Male	**Insurance**	Medicare
Living Situation	Lives with spouse in a single-level home				
Primary Diagnosis	History of falls (R29.6), recent ED visit for fall				
Comorbidities	Parkinson's disease, hypertension, mild cognitive impairment				

Recent Clinical History	Current Status (Home Visit Today)
• Fell in bathroom 2 weeks ago, no fracture but bruising • ED visit, discharged home with no follow-up • No PT/OT referral • Medications include antihypertensives and carbidopa/levodopa • No fall risk assessment documented	• Shuffling gait, poor balance • No grab bars or assistive devices in home • Spouse unaware of fall prevention strategies • Reports occasional dizziness • No emergency plan or alert system in place

Minimizing Falls at Home



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

***Multi-complexity**

Minimizing Falls at Home

Cost Reduction Strategies

- Avoiding ED visits through proactive care
- Use of PT/OT in the home
- Caregiver training and support & goals of care discussions

Minimizing Falls at Home

Coding & Billing

- ICD-10: R29.6 (fall risk), W19 (unspecified fall) Z91.81 (HX of)
- TCM after ED/hospital discharge
- Document risk factors and interventions

Minimizing Falls at Home

Coding & Billing

- ICD-10 W00-W19 are for reporting specific "fall" events
- W00-W19 can never be coded as a primary diagnosis
- The final character will define episode of care:

"A" Initial encounter or active treatment

"D" Subsequent encounter, routine healing/recovery phase

"S" Sequela: Used for complications or conditions that arise as a direct result From the injury

Example: W19.XXXA

Minimizing Falls at Home

Coding Clarity: What's the difference?

R29.6 *Repeated falls, falling, tendency to fall* – This Dx is best reported when the physician/provider is actively investigating causative factors; there have been multiple falls between encounters...

Z91.81 *History of falling, at risk for falling* – This Dx is best used when the patient has a history of falling but is not under "active investigation" for a current fall.

Poll Time! Let's Hear From You

Do you routinely assess fall risk in your HBPC patients?

- ❑ *Yes, for all patients*
- ❑ *Only for those with prior falls*
- ❑ *No, but planning to*
- ❑ *No*

Open Discussion: ***What's one change you could make to reduce urgent visits?***

Urgent Visits

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Urgent Visits

Common Patient Concerns

- Cardiovascular or respiratory issues
- Altered mental status
- Infection concerns
- Skin issues
- Musculoskeletal problems
- GI symptoms

Urgent Visits

- Assessing patient's condition and goals (Triage protocol)
- Provider's geographic location and availability (today, tomorrow, this week)
- Availability of home health, ancillary services (labs, imaging)
- Telehealth capability
- Access to prescriptions, medications (timely pick up of meds)
- Office follow-up post urgent call
- Tracking of urgent calls (timeliness, intervention, outcome)

Key Takeaways

- Proactive management reduces avoidable costs
- Coding and documentation drive revenue and compliance
- HBPC teams are uniquely positioned to lead value-based care

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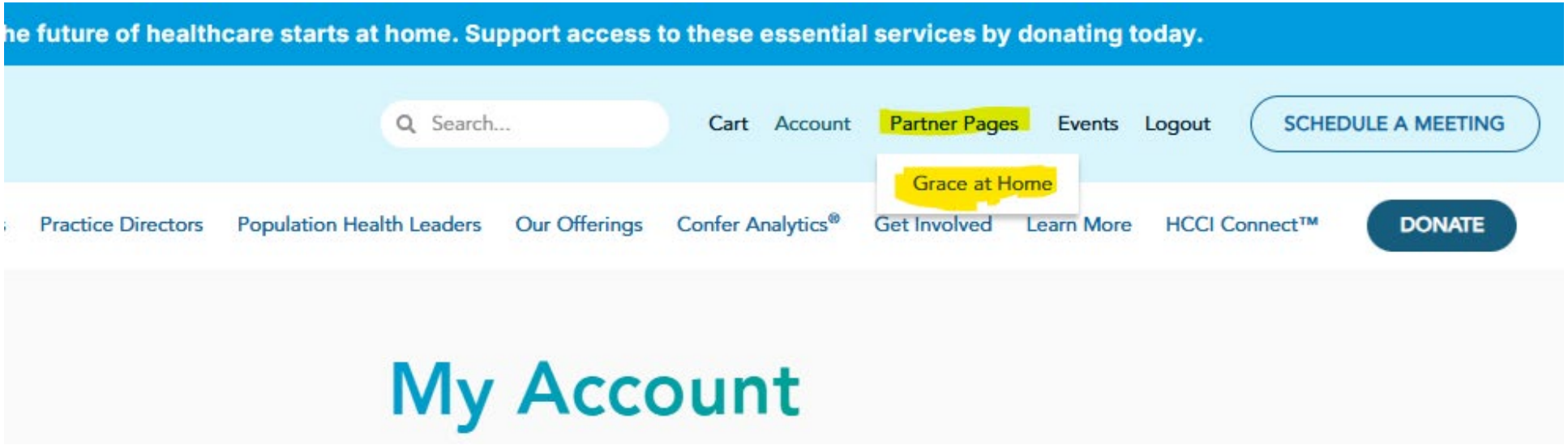

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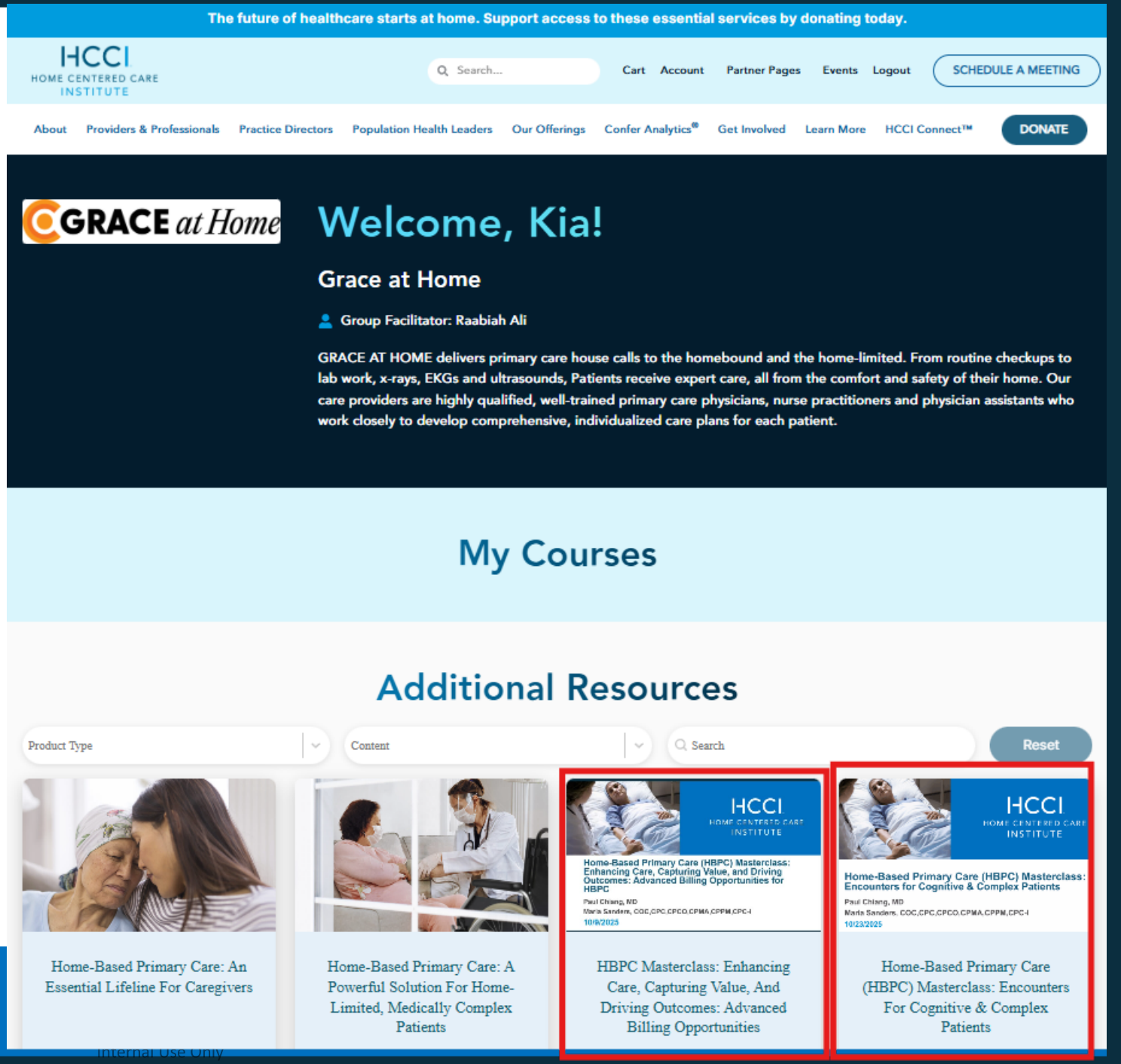
How to Access Webinar Recordings (cont.)

Step 3: Recordings will be available on the Grace at Home Partner Page



Home-Based Primary Care (HBPC) Masterclass: Optimized Management in HBPC to Improve Clinical Outcomes and Reduce Avoidable Costs (Part 2)

Focus: Up-to-date strategies for managing some of the more common (and costly) medical conditions encountered in HBPC

Topics:

- Polypharmacy/Medication Management
- Depression and Anxiety
- Dementia
- Documentation & Coding Tips

Thursday, December 4
3:00 - 4:30PM

For any questions, please contact Raabiah Ali, *Program Manager*
RAli@hccinstitute.org