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A Watched Pot Never Boils: Why Observing Swallowing is Unsuccessful and Risky

Katie Holterman, MS, CCC-SLP, BCS-S

Moderated by:
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A Watched Pot Never Boils: Why Observing Swallowing is Unsuccessful and Risky

Katie Holterman, M.S. CCC-SLP, BCS-S

Disclosures:

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- Non-Financial Disclosure: Member of American Speech and Hearing Association Healthcare Economics Committee. SLP Advisor for American Medical Association (AMA) CPT committee.

Learning Outcomes

After this course, participants will be able to:

- Describe differences between dysphagia screening, assessment and treatment, and elements which overlap between the three components.
- Identify the CPT codes related to swallowing and explain how to decide which CPT codes to utilize.
- Describe 2-3 principles of exercise science and neurorehabilitation principles as they apply to the treatment of dysphagia.

A Watched Pot Never Boils– the Science of it all….

- The proverbial expression 'a watched pot never boils' refers to the feeling that time seems to go slower when you are anxiously waiting for something to happen…

Watching the pot is useless

- Why?
  - The solubility of gases decreases when the temperature is raised, and that is why the dissolved air bubbles go out from the water. Then, as the boiling point of water is reached (212 degrees Fahrenheit), water vapor starts to form inside the liquid in the form of bubbles.
  - It is not magic. It is not an unexplainable event. It is not something that just "happens" (i.e. improves) over time. It is an event that occurs because of **SCIENCE**
  - So…
    - What happens when you never turn on the stove???

Skilled Therapy

- In order for a service to be considered skilled,
  - It must have a benefit category (√)
  - Services must be **reasonable and necessary**

CMS Publication 100-02. Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B).

Reasonable and Necessary

- The services shall be considered under **accepted standards of medical practice to be a specific and effective treatment for the patient's condition**. Acceptable practices for therapy services are found in:
- Medicare manuals (such as this manual and Publications 100-03 and 100-04),
- Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: http://www.cms.hhs.gov/mcd), and
- **Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology**.

Reasonable and Necessary

- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy, by or under the supervision of a therapist.
  - Complexity and Sophistication: Services are complex or condition is complex….
- Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

Reasonable and Necessary

- Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, **but rather on the beneficiary's need for skilled care.** While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis cannot be the sole factor in deciding that a service is or is not skilled. The **key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel**

Reasonable and Necessary

- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

  (Amount, frequency and duration of services must be reasonable for the condition present…..)

Dysphagia Screen, Evaluation and Treatment

- Screening:
  - Binary conclusion: + or – for likelihood of existence.
  - Determine need for referral for assessment
  - Swallowing screening is a pass/fail procedure to identify individuals who require a comprehensive assessment of swallowing function or a referral for other professional and/or medical services (ASHA, 2004b)

Evaluation/Assessment:

- the purpose is to identify and describe:
  - typical and atypical parameters of structures and functions affecting swallowing;
  - effects of swallowing impairments on the individual's activities (capacity and performance in everyday contexts) and participation; and
  - contextual factors that serve as barriers to or facilitators of successful swallowing and participation for individuals with swallowing impairment

- Treatment: Treatment of dysphagia may include restoration of normal swallow function (rehabilitative), modifications to diet consistency and patient behavior (compensatory), or some combination of these two approaches (From ASHA's Practice Portal: Adult Dysphagia)

Dysphagia Screening

Examples:

- Maxwell Swallow Screen
- 3 Ounce water swallow screen
- Barnes-Jewish Hospital **Stroke Dysphagia Screen** (BJH-SDS)

Dysphagia Screening

- Screening protocols /components
- Interview
- Observation of presence of signs/symptoms of dysphagia
  - Most often occurring during routine/planned PO intake/situations
- Administration of standardized screening test (i.e. 3-oz water swallow test)
- Recommendation for additional assessment
- Communication of results and recommendations to healthcare team

Dysphagia Screening

- The WHY of a screen.
- Symptoms yes or no?
- Does this person need further assessment and/or intervention?
- OBSERVATION

CONTINUED

Dysphagia Evaluation

- Elements of an Evaluation/Assessment
- Thorough review of medical history
- Interview with caregiver and/or patient
- An (brief) oral mechanism exam, including one or more of the following:
  - Cranial nerve assessment
  - Structural and functional assessment of muscles and structures used in swallowing, including symmetry, sensation, strength, tone, range and rate of motion, and coordination of movement
  - Observation of head–neck control, posture, oral reflexes, and involuntary movements
- Assessment of overall cognitive/communicative status

CONTINUED

Dysphagia Evaluation (cont.)

- Assessment of speech and vocal quality at baseline and any changes following bolus presentations
- Monitoring of physiological status, including heart rate and oxygen saturation
- Presentation of various textures and assessment of effects of bolus delivery and/or compensatory strategy use.
- Assessment of secretion management skills
- *****Observation of the patient eating or being fed food items with consistencies typically eaten by the patient in a natural/typical environment for the patient's situation*****
- Assessment of labial seal and anterior spillage, and evidence of oral control, including mastication and transit, manipulation of the bolus, presence of hyolaryngeal excursion as observed externally or to palpation, and time required to complete the swallow sequence
- Identification of signs and symptoms of penetration and/or aspiration, such as throat clearing or coughing before/during/after the swallow
- Assessment of cough strength
- (ASHA: https://www.asha.org/Practice-Portal/Clinical-Topics/Adult-Dysphagia/)

Dysphagia Evaluation - Instrumental

- Indications for Instrumental Examination(MBS/FEES)
  - *****Assess physiology – able to accurately guide management/treatment*****
  - Non-instrumental provides inconsistency
  - Differential diagnosis
  - Presence of a medical condition or diagnosis associated with a high risk of dysphagia

Dysphagia Treatment

- Rehabilitative - Restoration of normal swallow function
- Compensatory - Modifications to diet consistency (a) and patient behavior (b)
- Rehabilitative - Active
- Compensatory - Passive (a) or passive/active (b)
- Combination…

Dysphagia Treatment

- "Compensatory techniques alter the swallow when used but do not create lasting functional change….. Rehabilitative techniques, such as exercises, are designed to create lasting change in an individual's swallowing over time by improving underlying physiological function"
  - (ASHA: https://www.asha.org/Practice-Portal/Clinical-Topics/Adult-Dysphagia/)

"Compensatory techniques alter the swallow when used but do not create lasting functional change…..

- Diet modifications
- Compensatory strategies

Dysphagia Treatment

- Rehabilitative techniques, such as exercises, are designed to create lasting change in an individual's swallowing over time by improving underlying physiological function

Dysphagia Treatment

- *Maneuvers* are specific strategies that clinicians use to change the timing or strength of particular movements of swallowing.
- Effortful Swallow
- Mendelsohn Maneuver
- Superglottic
- Super-supraglottic

Dysphagia Treatment

- "Oral Motor" Exercises
- Laryngeal Elevation
- Masako
- Shaker**
- Lingual Isometric exercises/ Lingual Resistance
  - What is being targeted and does it make sense??
    - IOPI vs. Tongue Depressor
    - Where is tongue pressure?

Dysphagia Treatment

- Principles of Exercises Science:
- Neuroplasticity- core
  - Use it or lose it
  - Use it and improve it
  - Specificity
  - Transference ***
  - Intensity **
  - Repetition
  - Time

Dysphagia Treatment

- Use it or lose it
- Deconditioning
- NPO
  - Temporary vs. permanent
  - When choosing exercises does it apply or mimic actual swallowing physiology

Dysphagia Treatment

- Use it and improve it
  - "too weak"
  - "fatigue"
  - "waiting to improve"
  - "not alert"
  - Swallowing begets swallowing
  - Constraint-induced movement therapy (CIMT)

Dysphagia Treatment

- Specificity
  - Specific task of swallowing uses specific motor units…
  - Training that specific task works to strengthen the neural pathways needed for that task
  - Lingual resistance exercises
  - Tongue protrusion- greatest pressure occurs in mouth behind incisors
- Is this what we need to improve?

Dysphagia Treatment

- Transference
  - Practicing one skill can result in improvement of a related skill
  - Plasticity in response to one training experience can enhance acquisition of similar behaviors
  - How will a task or activity can be generalized or transferred to real world activities
  - Most related to compensatory strategy training/diet modification

Hierarchy of exercise science/neuroplasticity principles

Dysphagia Treatment

- Intensity
  - Not well researched
  - What is the proper dosage of therapy necessary?
  - How many sessions (Frequency)?
  - How long should these sessions be?
  - Research *in other areas* has also shown us that the more intensive the therapy program, the more likely a person is to achieve results and the more likely these changes are to be maintained over time

Dysphagia Treatment

- Repetition
  - An unknown but important principle
  - Don't know how many sessions… but insurance may want to know!
  - We do know that it is NOT one or two…. Or 10 or 20
  - HIGH number of repetitions of certain activities are needed to generate changes

Dysphagia Treatment

Dysphagia Treatment

- Personal Trainers:
  - Example 1 – I'm watching you run a mile and timing you. Faster faster faster!!!
  - Example 2- Run a mile with me. Correct my posture. Cue my breathing. Lift weights with me.
  - Which trainer gave me the best results?

CPT Codes

- 92610 – evaluation of oral & pharyngeal swallowing function (Clinical/non-instrumental)
- 92611- Motion Fluoroscopic evaluation of swallowing function by cine or video recording (MBS)
- 92613, 92614, 92615, 92616, 92617 – Flexible fiberoptic endoscopic evaluation of swallowing (FEES)
- 92526- Treatment of swallowing dysfunction and/or oral function for feeding
- All above are service codes (untimed)

Untimed CPT codes

- This means ~~unlimited ?~~
  This means ~~no time~~ needed?

Guidelines still are in place….

- Code development history:

CPT codes

92526- treatment of swallowing dysfunction

- Assessment of speech and vocal quality at baseline and any changes following bolus presentations
- Presentation of various textures and assessment of effects of bolus delivery and/or compensatory strategy use
- *****Observation of the patient eating or being fed food items with consistencies typically eaten by the patient in a natural/typical environment for the patient's situation*****
- Identification of signs and symptoms of penetration and/or aspiration, such as throat clearing or coughing before/during/after the swallow

Setting Differences?

- 92526. Universal
- 92610. Universal
- CPT codes do not differ based on setting. Should it be?
  - Evaluation - SNF vs. Acute Care. Acute care vs. outpatient or home health?
  - Treatment SNF vs outpatient. Acute care vs. SNF

Acute Care

- CPT Codes: Med A DRG
- Screening: RN
- Evaluation -
  - Instrumental accessibility
  - Time limitations
  - Patient complexity/medical conditions

Treatment -
- "Follow ups"
- Bedside vs. Department
- Immediate need?

Skilled Nursing

- CPT codes - Med A. RUG IV…. PDPM
- Screening -
- Hands off?
- Evaluation
  - Time? “set time”
  - Resources
- Treatment
  - Minutes?
  - Objective tools?
  - “home like environment” dining rooms…

Outpatient

- CPT codes - Insurance. Medicare Part B
- Screening -
  - Possibly part of evaluation
- Evaluation -
  - May consist of clinical non-instrumental or instrumental or both
- Treatment -
  - Patient condition improve?
  - Resources/tools

When Risk Meets Practice

Case Examples-

- Patient was seen bedside with spouse present. Trials of thin liquid provided. Patient observed to cough with thin liquids x6/10. With verbal cues to utilize chin tuck patient tolerated thin liquids without cough on 9/10 trials. Education provided to patient and wife regarding continuous use of chin tuck strategy.
- Patient seen during lunch. Patient noted to have good intake of chicken, yogurt and thin liquids. No overt s/s of aspiration noted. Patient with good rate of intake. Recommend continue with current diet. Discharge from speech therapy services.
- Patient seen with breakfast tray present. Oral motor examination completed. Labial and lingual strength appear WFL. PO trials provided puree, mechanical soft, nectar thick and thin liquids. Patient with reduced mastication of soft solids. Adequate bolus prep for puree. Throat clear noted after thin liquid trials by straw. No evidence of difficulty with nectar thick liquids. Recommend downgrade to nectar thick liquids.
- Oral motor exercises provided - patient with adequate lingual protrusion and resistance to tongue depressor improved from previous session. Base of tongue exercises provided with verbal cues required for accuracy. Patient utilized effortful swallow and double swallow during meals correctly 93% of the time as measured by palpation.

Case Examples- This is not ~~skilled~~ therapy!!

- Patient was seen bedside with spouse present. Trials of thin liquid provided. Patient observed to cough with thin liquids x6/10. With verbal cues to utilize chin tuck patient tolerated thin liquids without cough on 9/10 trials. Education provided to patient has wife regarding continuous use of chin tuck strategy.
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- Oral motor exercises provided- patient with adequate lingual protrusion and resistance to tongue depressor improved from previous session. Base of tongue exercises provided with verbal cues required for accuracy. Patient utilized effortful swallow and double swallow during meals correctly 93% of the time as measured by palpation.

Example 1

- Patient was seen bedside with spouse present. Trials of thin liquid provided. Patient observed to cough with thin liquids x6/10. With verbal cues to utilize chin tuck patient tolerated thin liquids without cough on 9/10 trials. Education provided to patient and wife regarding continuous use of chin tuck strategy.
- 92526. Second visit with patient who was s/p CVA in hospital. No instrumental provided prior. Follow up with patient and wife the next day - patient and wife unable to recall education provided and when or how to use chin tuck. Unclear rationale of chin tuck. Instrumental 3 days later demonstrates increase silent aspiration of thins with chin tuck strategy

Example 2

- 1/1/17 - Patient seen during lunch. Patient noted to have good intake of chicken, yogurt and thin liquids. No overt s/s of aspiration noted. Patient with good rate of intake. Recommend continue with current diet. Discharge from speech therapy services.
- Evaluation completed 12/15/16.
- MBS completed 12/24/16 (recommendation regular solids and thin liquids - impaired timing of VC closure with resulting bolus entry to level of vocal cords before the swallow on 50% of trials– effectively cleared each time with a reactive throat clear)
- Patient seen for "follow up" treatments (each session billed 92526) 5 more times (12/26, 12/28, 12/29, 12/30, 1/1)
- Notes for each follow up session read. Patient seen during mealtime. Patient with good intake of prescribed diet (regular solids and thin liquids). Minimal throat clear noted with thin liquids. Patient appears to have fast rate of intake with solids however no overt s/s of aspiration.

Example 3

- Patient seen with breakfast tray present. Oral motor examination completed. Labial and lingual strength appear WFL. PO trials provided puree, mechanical soft, nectar thick and thin liquids. Patient with reduced mastication of soft solids. Adequate bolus prep for puree. Throat clear noted after thin liquid trials by straw. No evidence of difficulty with nectar thick liquids. Recommend downgrade to nectar thick liquids.
  - Evaluation or Treatment??????

CONTINUED

Example 4

- *Oral motor exercises provided - patient with adequate lingual protrusion and resistance to tongue depressor improved from previous session. Base of tongue exercises provided with verbal cues required for accuracy. Patient utilized effortful swallow and double swallow during meals correctly 93% of the time as measured by palpation.*
- Oral motor exercises provided - why?
- Patient with adequate lingual protrusion and resistance to tongue depressor improved from previous session. Base of tongue exercises(which ones?) provided (so what does provided mean? Did you teach how to do, did you provide written instructions, did the patient DO anything) with verbal cues required for accuracy (why did the patient need verbal cues? Verbal cues for what? How are you testing accuracy?) Patient utilized effortful swallow and double swallow during meals correctly 93% of the time as measured by palpation.