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

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- [Amy] Once again, welcome to our webinar today, A Watched Pot Never Boils: Why Observing Swallowing is Unsuccessful and Risky. Our presenter today is Katie Holterman, and she is Director of Clinical Education and Compliance for EnduraCare Acute Care Services. She is board-certified in swallowing disorders and is a certified dementia care instructor through Dementia Care Specialists. She serves as a member of the Professional Development Committee for ASHA's SIG 13. She's also a member of ASHA's Healthcare Economics Committee and served as an advisor to American Medical Association's CPT Health Care Professionals Advisory Committee. Having nearly 20 years of clinical experience, Ms. Holterman has both provided clinical care and held leadership roles in a variety of clinical care settings, including acute care, hospital outpatient, subacute rehab, long-term care, and private practice. Ms. Holterman has presented nationally on topics including dysphagia and professional issues in rehabilitation. And we're very pleased to welcome back Katie. I'm gonna hand over the floor to you, Katie.

- [Katie] Thank you so much, Amy, I appreciate it. Hope everyone can hear me. So I'm gonna start this just by, I have presented with SpeechPathology.com Continued before, and it's such a great company, it's so professional. And I like to uphold that standard. I like to be professional in my presentations. That being said, I do present this from my home office, and as such, things occur, like a dog that loves to bark. And so with that, please don't let that take any professionalism aside. I just like to think of it as, hey, the beauty of e-learning is that you can do it in the comfort of your living room. And so let's pretend that we're in my living room and we're havin' a cup of coffee, or a glass of wine if you wish, and we're talkin' about some swallowing and dysphagia. And if you hear the dog, just ignore him. With that being said, we'll get started on today's presentation. I am really excited to present this topic, as it's something I'm very passionate about, something that I feel like we, as clinicians, really need to talk more about this and talk

about what's actually going on in the field, how we're practicing and how we can improve ourselves. And so without further ado, let's get started with this. Of course, the disclosures, just to let everyone know, financial disclosure, I have received a financial stipend from SpeechPathology.com for this course. And non-financial, I just always list anything that I'm a part of, member of American Speech and Hearing Association Healthcare Economics Committee and was an advisor for the American Medical Association CPT committee. And again, not really part of this presentation, but I just always like to list those things. For our learning outcomes, hopefully by the end, you will have the ability to describe differences between a dysphagia screening, an assessment, and treatment, and which elements may overlap between those three components, or three elements. Identify the CPT codes related to swallowing. And explain how to decide which CPT codes to utilize. And is there one better than the other? And are we using them correctly, also? Describe two to three principles of exercise science and neurorehabilitation principles as they apply to the treatment of dysphagia.

Okay, so a watched pot never boils. We've all heard it, right? This expression means that, it refers to that feeling, that time that just goes slowly when you're anxiously awaiting for something to happen, right. We all know watching that pot is useless. So that's the figurative meaning. But the literal meaning of watching the pot and it will never boil is, well, there is a literal meaning to it, why just watching that pot is useless. Well, there's a science behind it, okay. And without getting too geeky, the science of this is that the solubility of gases decreases when a temperature is raised. And then you have these air bubbles that go out from the water. The boiling point of water is reached, 212 degrees Fahrenheit, and then water vapor will form, and then you get these bubbles, right. It's not magic. It's a science. And so why am I going over this? Well, because dysphagia and dysphagia treatment is a science, it's not just haphazard. So then I have to beg the question, what happens when you never turn on the stove, right? What happens if you don't apply any heat to the water? The pot is never going to

boil. The water is never going to boil. So we can say that if you don't actually perform any exercise for swallowing, the swallowing is not going to get better. So the figurative example is really the same as the literal example, and it can be translated directly into our dysphagia treatment. Okay. So the first thing we're gonna talk about is what is, we need to define what skilled therapy is. And why am I going to a Medicare Benefit Policy Manual? Well, we all know Medicare is kind of the king of the therapy castle, right? Medicare is, number one, I would say a majority of our patients are those that are Medicare beneficiaries, right.

Of course, we do have other patients who have other insurance types, but again, Medicare is the king of the castle. And so other third-party insurance will often follow suit of Medicare. So we need to have this definition from Medicare of what skilled therapy is. And we need to always keep that at the forefront of our minds. In order for a service to be considered skilled, it must have a benefit category, which speech pathology does, and the services must be reasonable and necessary. So I often have people tell me that's so vague. What does that mean? Well, the Medicare Benefit Policy Manual spells it out for us. Okay. In order to be reasonable and necessary, this is directly from chapter 15, the services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.

Okay, and this is where acceptable practices for therapy services can be found: Medicare manuals, local LCDs, and the guidelines and literature of the professions of PT, OT, and speech. So this guidelines and literature, this is translating to evidence-based practice. So in order to be reasonable and necessary, in order for a therapy to be considered skilled, it has to be reasonable and necessary. And in order to be reasonable and necessary, it has to be backed by evidence-based practice. 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, okay. And then we won't go into PT and OT, because

we're talking about speech. So again, this is directly from the Medicare Benefit Policy Manual, complexity and sophistication. The services are complex or the condition is complex. Services that do not require the performance of a therapist are not skilled, so they're not considered reasonable and necessary, okay, even if they're performed by a qualified professional. That means that just because you have SLP after your name doesn't make the treatment that you're doing skilled, okay. It actually has to be a level of complexity and sophistication that only an SLP who has gone to school, gone through practice, and knows the evidence-based practice, only an SLP with that level of sophistication can perform these exercises and can perform this type of therapy.

Okay, again, Medicare coverage does not turn on the presence or absence of potential for improvement but on the beneficiary's need for skilled care. Again, I'm jumping down to the end. The key issue is whether the skills of a therapist are needed or whether they can be carried out by non-skilled professionals. So again, remember, it all is based on what is, how is the therapy that is being provided, is it that the skills of a therapist are needed? Okay, and again, the amount, frequency, and duration of the services must be reasonable under accepted standards of practice. What that means, amount, frequency, and duration of services must be also reasonable for the condition present. If we are seeing a patient for dysphagia services and the amount, frequency, and duration needs to be matching what that condition would meet. It may be very different than another condition. It may be very different from one person to another. But it must be reasonable.

Okay, so I want everybody to kind of keep that in the back of your head as we move forward, because we're going to go back to these themes of skilled therapy and reasonable and necessary throughout the presentation today. So now that we've gone there that, let's talk about the different elements, the different components of what we can do for intervention for dysphagia. We have dysphagia screens, we have evaluations, and we have treatments. And under evaluations, we have clinical

assessments, or bedside, and then we have instrumental assessments. So we're gonna delve into a little bit of this going forward. Screening, remember, is a kind of a binary conclusion. It's either the presence or absence, a pass or a fail. Is there something that indicates a condition is present or is there not? It's really a first step. It's really something that you are looking at to see if you need to go a little further into something that is a little bit more comprehensive.

So it's very simplistic. If we move away from dysphagia and we think about it from the perspective of kind of medical conditions, think about other screens that we have. When I was in the hospital and I gave birth to my son, they gave me a postpartum depression screen. It was kind of a survey. And it was just a question and answer. And it was to see if there was the indication that postpartum depression may be present. And then what they would do from there is, if I had those symptoms, I would then be referred for an evaluation, similar to a cardiac screen that you may have. Is there a need for additional evaluation? Very, very simplistic and a first step, so to speak. The evaluation or assessment, on the other hand, is a little bit more, or really, more complex. The purpose of that evaluation is to identify and describe any atypical parameters of structures, the effects of swallowing on the activities and how that impacts the patient on a day-to-day basis, any other factors that serve as barriers. It really goes more in depth into what could be occurring. Just a note, for this, you can go from evaluation/assessment into treatment.

Now, you may do an evaluation and say, okay, there's nothing more that I need to do. Similar to a medical procedure, you go in and you have a full examination, and there may not be any further indication for further services. On the other hand, you could, of course, have the need for treatment. And so again, with dysphagia, you may have treatment which includes restoration of a normal swallow function, what we call rehabilitative, or modifications to diet consistency and patient behavior, which are more compensatory, or a combination of these two approaches. And that comes directly

from ASHA's Practice Portal. Just a plug on that, if anybody has not gone to the Practice Portal on ASHA's website, it is a wealth of information. So I highly recommend that if you haven't gone there, do so. Take a look at the information that's there. And it really breaks down a variety of topics for dysphagia. It breaks down the research. And it goes in depth into what is needed for each of these components.

Okay, so dysphagia screening, I just gave a couple of examples. These are by no means a list of all of the examples of dysphagia screenings that are out there. There are a million. And there are also dysphagia screenings that are not standardized. There are ones that, I know certainly hospitals have ones that kind of were made up by that hospital. Remember, as long as it is a screening that is giving some sort of a prediction, indication of something that may need to be further investigated, that would be a screening. But some of the more popular ones, the 3-ounce water swallow screen is one that's, I know that several people use, several colleagues. There's the Maxwell Swallow Screen, the Barnes-Jewish Hospital Stroke Dysphagia Screen. And there are several others, of course.

Okay, so what is a dysphagia screening? What's involved in this? I apologize, I'm having technical difficulties. I'm hoping that I, there we go. I'm sorry about that. What are the components of a dysphagia screen? There is an interview that maybe, or usually, is pretty brief. There is the observation of presence of signs and symptoms of dysphagia. This most often occurs during routine/planned PO intake or situations. So in other words, maybe a meal at bedside or something similar. It will occur in what, hopefully, is the patient's most natural environment. You may also have an administration of some standardized screening test, such as the 3-ounce water swallow screening. But most of the time, or not most of the time, but sometimes you will just have a simple observation. And then again, that recommendation for additional assessment and communication of results and recommendations to the healthcare team. But at the basis of it all, it's an observation, right. Why are we doing this? Well,

we need to determine if the patient needs further assessment and/or intervention. Okay, so then we get into an evaluation. So we take it one step further, right. And this is definitely more comprehensive. I'll go into the components in a little bit. But what I want, I always try to translate this from, kind of give real-life examples. So about a year ago, I was having some pain in my shoulder. And I kind of lived with it for a little while.

And finally, I just said, I can't take this anymore. And I went to my doctor. And he said, "Yeah, you know, "I see that that could be something." He did a pretty thorough examination of it. And then he referred me over to physical therapy. And physical therapy did their evaluation. And they worked together with the physician to come up with a diagnosis and a treatment plan, okay. And remember that analogy as we work together with the physician. I think sometimes we get onto our diagnostic track, and we need to be pulled in and say, okay, we need to make sure we're including the physician in this whole thing. But that physical therapist did this evaluation. It was pretty thorough. And I'm gonna pause on that story until we go through this. And I'll come back to that.

So the elements of an evaluation are a fairly thorough review of a medical history and a fairly thorough interview. So in differentiation with the screening, where you had that brief interview, you're gonna wanna go in depth with the evaluation. You may do the oral mech exam and look at one or more of the following. And I won't read through the slide, but if you're doing an adequate clinical examination, you're gonna be looking at quite a fee things during your oral mech exam. And you're gonna make sure that you're looking at various levels of these components. You're gonna take a look at the overall cognitive communication status, because we all know that can have an impact on somebody's swallowing. You're going to look at speech and vocal quality. And then you're gonna be very in tune to looking if there's changes following the presentation of bolus. We're going to be monitoring the physiological status, presentation of various textures. Okay, so we're actually gonna be giving the different textures, and then

assessment of the effects. We're gonna look at secretion management. And we're gonna observe the patient, okay. And this is highlighted for a reason. Remember we were talking about observing the patient. So we were observing the patient in screening and observing the patient in evaluation, okay. So we're gonna pause here. Observation, right, watching the pot. When we're doing observations, we are not trying to to improve the swallow at this point. During a screening, during an evaluation, we are assessing, right. And so we are observing the patient. Notice that's all under evaluation.

Again, assessment of labial seal, excuse me, anterior spillage, oral control, all of that, I'm not gonna go into everything, and then assessment of cough strength. Again, this is from the Practice Portal, highly recommend that everybody takes a look at that. And then, of course, we're gonna take a look to see if we need to do an instrumental. So I wanna pause here and go back to my PT story. There is a myth that dysphagia evaluation should never result in recommendations for specific therapy techniques. But that's not true. There are techniques that can be derived from an evaluation, from a clinical assessment. And so if we think about my shoulder, that PT did a lovely evaluation and came up with a lovely plan of care, and didn't rush me to an MRI, didn't rush me to a CAT scan or an X-ray. Because there are some things that can be determined from a clinical evaluation.

Now, in contrast, a few years back, I broke my ankle. And I remember being in that hospital ER, and they needed an X-ray. And we think, okay, well, of course you need an X-ray to find out if something's broken. But it was not just to find out if something was broken. It was to find out how it was broken. In other words, was it a displaced fracture or a non-displaced fracture? Because the treatment for those two fractures are very different. One requires a cast, and possibly surgery. One requires just a walking boot, or maybe just a cast, but no surgery. The type of fracture was different. And that's the reason that the X-ray was needed. So again, going into your instrumental exam, it is

not to determine if there's aspiration or if there is this certain swallowing dysfunction. It's to determine the details. And again, going back to my shoulder, there are some things that could be, I didn't need that MRI. There was a perfectly good evaluation that a treatment plan was developed from. And then there's the point of an instrumental when an instrumental is needed. Okay, so there are reasons that an instrumental would be needed. And they are listed below. When you have the need to further assess physiology, when the non-instrumental is completely inconsistent, when you need a differential diagnosis, or when there's a medical condition that is associated with that high risk and you need a little further indication.

So then we have our treatment. Treatment can be rehabilitative, compensatory, or both, right? Rehabilitative we think of as more active, active exercises. And then compensatory can be either passive, when we think of diet modifications, right, or passive and active. If we think about changing that diet consistency, remember, we're changing texture, temperature, viscosity, sensory, or size. And then patient behavior would be more of those compensatory strategies or positional techniques. But we can have a combination of, and we probably should have a combination of all of these. This passive and active is not referring to what you did. It's the patient action, right. Modifications to a diet consistency is passive, because the patient didn't do anything. You did, and it's okay. The patient didn't have to do anything, and it doesn't mean you didn't, but that's more important reason to document the skill needed in what you did. Because it is a form of a passive treatment method.

And so the documentation of skill is even more important in those types of methods. And I just love this statement from the ASHA Practice Portal. "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 that underlying physiological function." Okay, think about that, right, rehabilitative techniques designed to create

lasting change. So do we wanna create lasting change, lasting function? I'm pretty sure the answer would be a resounding yes for everyone. All right, so we're gonna go into a little bit of dysphagia techniques, treatment. We have maneuvers that we can use. They are specific strategies that you can use to change the timing, the strength of swallowing. Some of the more common ones that we use are the effortful swallowing, the Mendelsohn, the superglotic, or the super-supraglottic. I'm not going to go into, for the sake of these presentation, I'm not gonna go into each of these treatment techniques. Hopefully, you have an understanding of each of these prior to this webinar.

But again, the maneuvers are the strategies that you would use during swallowing. And then you have oral-motor exercises, okay, laryngeal elevation, Masako. I always mess this up. I never know if it's Shaker or Shaker. So I kind of go back and forth. And one of these days, I really should get the pronunciation correct. And then lingual isometric exercises. So if we take the first three, these oral-motor exercises, that's really pretty broad, right. We're gonna go into a little bit of those. But be careful with this term. Because there are oral-motor exercises that have been proven to be non-beneficial. And then there are oral-motor exercises that are beneficial and have good research, but they're not really oral-motor exercises.

Although, they're used in that grouping. But that and laryngeal elevation and Masako, they've had some inconsistency in their research and the benefit of them, so tread cautiously. The Shaker method has been proven. It has high-quality evidence from random controlled trials to have a good benefit on swallowing. And then lingual isometric exercises, or lingual resistance, when you're doing these, you just wanna think about what is being targeted, and does it make sense, right? So an IOPI, for example, versus a tongue depressor. If anybody's familiar with the IOPI, it's a device that's used for lingual resistance. And then we've all had those instances where we use a tongue depressor, right? But my measurement of tongue strength with a tongue

depressor may be vastly different than yours or the person down the street. We have no norms for this. And there was actually a study. I think it was Heather Clark who did a study that, she measured the inter-rater reliability of tongue pressure using a tongue depressor, and the results were all over the place. So we really need to have objective measurements for these types of exercises. But with that, with the use of an IOPI, or with the use of other methods, dysphagia treatment and these active exercises can really make a difference in rehabilitating the swallow. And then we look at the principles of exercise science, and more specifically, neuroplasticity. There is a great article by Robbins and all in 2008, "Swallowing and Dysphagia Rehab: "Translating Principles of Neural Plasticity "Into Clinically Oriented Evidence."

And I believe that is on the reference slide. But it is a wonderful article in regards to exercise science and neural plasticity. And we're gonna go into some of these concepts and think about how we can tie this into our everyday treatment. Neuroplasticity is, again, it has various elements. The first one is use it or lose it, right. Think about, if you don't use a muscle, you're gonna decondition that muscle, right. Think about learning a foreign language. This is where I always think about how use it or lose it makes sense to me. I used to take French for six years through college. And I was really good, but then I didn't use it, and so I lost it. I can say very few words now. Same thing thing with our musculature, right. If we don't use it, then we lose that ability to use it as well.

And this is where deconditioning comes into play. So if we have a patient and we're making this patient NPO, think about, how is that helping the patient, really? And when choosing exercises for a patient who's NPO, we wanna make sure that it mimics actual swallowing physiology to the best of our ability. Because then we make sure that we're using the muscles in the way they were intended. We have use it and improve it, okay. So some of those excuses, for lack of a better word, that I've heard are that the patient is too weak, tires too much. We're waiting to, this is my favorite. We're just waiting for

the patient to improve. Okay, 'cause that works, waiting. You know, awesome. Or the patient's not alert. Well, I hear where you're at with that. It is hard to do swallowing when a patient is not very alert. But just remember that swallowing begets swallowing, right. The patient won't be able to improve unless they use their muscles correctly. So we have to remember that this also works best if the activity involves more than just rote practice, but it is actually specific to that activity.

So think about, again, from a PT example, you may go to PT, and they may say, okay, let's just strengthen up a muscle by doing leg extensions. It's actually better to walk. That's going to help improve that muscle in the best way that we can. Specificity, again, it's right in that word, being specific, right, using the exact action or function or muscle movements that are needed. It has a direct application to swallowing therapy, because we need to make sure that we're using this, we're training the task that we need to train and that the task of swallowing is using those specific motor units. So we wanna make sure we're using exercises that target the specific motor units used. I use the example of lingual resistance again. If you're telling a patient to stick out their tongue in hopes to get an improved swallow, then you're really not doing the patient justice. Because actually, when you're sticking out your tongue, the greatest pressure is right behind the mouth, or right behind the incisors, right in the front. Now, we know, for swallowing, we need that strength to be in the back.

So again, be specific to what you need to be improving. Randomly using muscles that are sort of related to swallowing is not going to help swallowing. And then the concept of transference, practicing one skill can result in improvement of a related skill. Think about this in relation to compensatory strategies, right. If we can generalize that to real-word activities, real-word concepts, it's going to have a better effect on the patient function. Telling a patient while they're drinking nectar-thick liquid, or while they're taking spoonfuls of applesauce, to do a compensatory strategy may work, and it may translate into the real function. However, when you think about this concept, think

about trying to get as closely related to that actual activity that you want. So if the patient doesn't like applesauce, they're never going to wanna translate that to regular food that they would like. So if the patient likes chocolate pudding, use chocolate pudding, right. And again, with some of our swallowing techniques or exercises, you wanna get that as closely related as you possibly can. Okay, intensity. Now, I have not well-researched, but I say that with a caveat. It is researched. I just think that we can do a lot more with research in this area. But Lori Burkhead Morgan has done wonderful work in this area, in the area of intensity and exercise science. I don't fangirl out much when it comes to swallowing experts, but Lori Burkhead Morgan and probably Jim Coyle are the two that I would fangirl out with. 'Cause I just find Lori's work to be amazing. But she has done some great work.

And she has stressed importance not only that we need to look at the proper dosage and how many sessions, and how long should these sessions be, but that also, the point of how hard we're working the patient. So you have to work the patient to the point of fatigue versus this random number of reps or weights that we choose with no scientific backing on that at all. Okay, and then the idea of repetition, this is an unknown but very important principle. We don't know how many sessions, right. We haven't has enough research.

But insurance wants to know. They're looking, they wanna know, exactly how long is it gonna take you to get this patient better? If we're thinking kind of just realistically, the more intense that you can be in your treatment, then the better it's going to be, and the faster it's probably going to be. We know that it's not gonna be just one or two sessions. And it might be 10 or 20, it might not be. But we know that the high number of repetitions of certain activities are needed to generate changes in other areas. We know that from other research. So it would lead us to believe that repetition would be the same in the principle of dysphagia treatment. Okay. I used to have a magic wand in my office, because I would inevitably get a call from nursing saying, "Oh, we'd like you

to reevaluate the patient today, "because they're better." and so I would pick up my magic wand, and I'd walk over to the room, and I'd say, "Oh, here, I have my magic wand to make them better," because in one day, because they're better in such-and-such an area, their swallowing's gonna be better. I didn't actually do that. I'm not that mean. But I really wanted to several times. We don't have magic wands, and we don't have magic eyes. And watching a patient or just reevaluating the patient over and over again is not going to make them better. We must actively participate in the session with the patient to create the change.

Okay, so let's think about this from a personal training perspective. If anybody's ever had a personal trainer, it's a lot of work. But I can tell you that I've had personal trainers before. And the first, no, he wasn't the first one, but maybe the second, and it's early on, would say, "Okay, I'm gonna watch you run a mile, "and I'm gonna time you." And then he would yell, "Faster, faster, faster!" That did nothing but annoy me. And I didn't really get that much faster. I may have gotten a little faster, but it certainly wasn't to what I wanted it to be. But I had another one, another trainer, who would say, "Okay, I'm gonna run a mile with you." And he would stand next to me, and he would correct my posture, and he would cue my breathing. And he would actually lift weights with me. And I got great results, right. He was active, he made me active, and he gave me actual things that I could use moving forward.

And so we wanna make sure that we're being the best trainers we can be when we're going forward. So we're gonna switch gears and talk a little bit about CPT codes. We're gonna tie this all together, I promise. But just a run-through of the CPT codes that we can use for swallowing, so we have evaluation of oral and pharyngeal swallowing function, so that clinical non-instrumental, 92610. We have 92611, which is our MBS. We have 92613 through 92617, which is our FEES. And then 92526 is our treatment. All of these codes are service codes, meaning they are untimed. Now, one that I don't have listed, or some that I don't have listed, are the physical medicine

codes. Those are timed codes. And they're not listed for a reason. Now, some, and actually, I should say a few insurance companies will allow these codes to be used. However, I would advise against this for this reason. Dysphagia therapy, that 92526, is a code that is, it's listed exactly as I have it here. It says the treatment of swallowing dysfunction and oral function for feeding. So it covers it all. If you use a physical rehabilitation code, for example, 97112 or 97530, neuromuscular re-ed or therapeutic activity, you're breaking down the components of what's actually a part of 92526. So you're being very duplicative in what you're stating. And from a perspective of coding, you're actually not being correct in how you're coding. You're stating that you've done something, that 92526 covers what you've done, but if you try to break it down into saying, okay, 92526 and the physical medicine rehab codes, you're being duplicative. So you wanna not to do that.

So untimed, again, all of our dysphagia codes are untimed. So does this mean it's unlimited? Does this mean that you don't have to do any time? You can still charge the code? No, guidelines are still in place. There's a built-in time or amount built into all untimed codes. So way back when, when I used to talk about coding and teach coding, I used to say, oh, well, if it's an untimed code, you can see the patient for three minutes or 30 minutes or 300 minutes, and it didn't matter. Well, I slowly started to realize that people were taking me literally. And they would see a patient for two or three minutes and say, oh, I can charge for that. And that's not true. That's not okay. You can't see a patient for three minutes and just because it's an untimed code say, hey, I did dysphagia therapy. And so what does that mean? Well, you can't sit at the dining room table with the patient and say, okay, let me check how you're doing your swallowing. Oh, I see that you're doing really well. You've used the compensatory strategy that I've taught you. Oh, wait, well, why don't you slow down a little bit. Oh, good, your pacing is good, and then charge the patient for that. And I know that that sounds crazy. But I hate to say, I've seen people do that. And that's not an okay use of your code. You're misrepresenting the amount of time built into that code. You're

misrepresenting what you've been doing, and you're not having skill involved in that. So just be careful with that. So I want you to go back and take a look at this. Now, remember, 92526 is the treatment of swallowing function, okay. These sentences that I've listed below are all things that are listed under that evaluation component, right, observation, presentation of various textures, assessment of speech and vocal quality, identifying signs and symptoms of penetration and aspiration, such as throat clearing or coughing. How many times have we seen in notes, or hopefully not written in notes, but if you have, that's okay.

We're gonna change that today. But how many times have you maybe written a note or read a note that said, patient observed to eat five ounces of purree, no cough noted, and that was a treatment session? But these are all listed under evaluation components. So charging 92526 for treatment of swallowing and doing any of these activities is really an assessment. It's really not a treatment of swallowing. You're not treating the swallow. Okay, and remember that our codes are universal. 92526, 92610, treatment of swallowing, evaluation of swallowing, they don't differ based on our setting.

So just because you work in a skilled nursing doesn't mean you use a different CPT code, right, just because you work in acute care or outpatient. Now, there's differences in the way that we'd bill based on the setting that we're in. And we'll go into that a little bit, but it's not setting-specific. So for acute care, you bill under what's called a DRG under the Medicare Part A benefit. And again, I'm going with Medicare. I understand that we have patients that have other insurance companies or insurance that they hold. But I'm going with Medicare because, again, king of the castle. The screening in acute care is usually done by nursing. The evaluation, we have that instrumental accessibility. It's right there. We do have time limitations. Because usually the patient's being brought in and out of a million things. And then we have patient complexity. Patients are really, really sick in acute care. And so we have all of these factors that can impact

an evaluation. So we usually, because they're so sick, because they're so complex, we end up doing a of reassessment. And I, personally, think that's okay. I think that that is what we need to do for those patients. But we have to be careful that we are not assuming that we are treating them one day, I mean, I'm sorry, evaluating them one day, and then follow-ups, so to speak, are being billed as treatment. They're not treatment. If you're following up on a patient, if you are just reassessing them, you're not treating them. You're reassessing them. So be clear in what you're doing. How often are we bringing them down to our department versus bedside?

And with that, I mean, can we really do what we need to do to rehabilitate the swallow at the bedside with alarms going off and doctors in and out? If you have the ability, would it behoove you to actually bring the patient down to a department if you have one to actually work on a little bit more of the swallowing that you need to work on and to make it more, to utilize all of those principles of neuroplasticity. Again, they're early on in their stage of their illness. So sometimes this may be that you just, a reassessment's what's needed. Okay. I know we're running, I wanna make sure we get through everything. For skilled nursing, right now we're in the RUG IV system for payment, and we're moving to PDPM for those of you in skilled nursing. Hopefully, you've heard about that. It's being implemented in a couple of months. But again, we have screening in skilled nursing, and that's generally a very hands-off type of observation.

And we have an evaluation. Now, sometimes there's a set time. There really shouldn't be. You need to use the amount of time that you need to use for an evaluation. But time can be limited. And again, there's this option of resources. You don't have all the resources that you might have in an acute care setting, such as access to an instrumental. I've heard that several times, that that's a difficult thing to access. Treatment, on the other hand, we have, right now, in the current system for payment, you have a certainly number of minutes that you're expected to be able to see a patient

in. And again, you need to be doing what's clinically appropriate for the patient and not what's set for a certainly number of minutes. You should be setting those minutes. But you have a certain number of minutes allotted for that patient, and so you have to make sure that you are using that time effectively for that patient and making sure that the treatment is scaled to maximize the benefit in those number of minutes that you have with them. Objective tools, do you have the objective measurements and tools that you would need to really provide the best care for that patient? And then you have the advantage of having that home-like environment in a dining room.

But be careful with that home-like environment, because I think that there are some times where we slip into that ability of sitting back and watching somebody eat, because it's in that dining room, and ooh, I can see four or five patients right in a row, because they're all sitting here. They've all come to me. But you have to make sure that, just because they're all there and it's that environment, that you're actually doing something with the patient, doing something that's going to represent the code that you're using and doing something that is skilled. Okay, similarly with outpatient, again, they have insurance, they have Med B. The screening would probably be more part of an evaluation. And the evaluation may consist of either clinical, non-instrumental or instrumental, or both. It depends on how your outpatient departments are set up.

And your treatment, the patient condition has generally improved through the acute care stage and the skilled nursing, and perhaps the home-health stage. So when you're seeing a patient in outpatient, you really, I think, have the most, you kind of have this clear slate in front of you, that clean slate in front of you, that you can say, okay, I can do all this treatment, because they're just a little bit more, or less acutely ill at this stage. And you probably have more resources and tools that you need. But that being said, it doesn't mean that just because you're in outpatient, or just because you're in acute care, or just because you're in skilled nursing, or what have you, that, okay, well, because I don't have the resources and the tools, or because I need to work in this

environment, and the patients are a little bit different with their complexity, that I'm just going to sit back and just do compensatory strategies, because compensatory strategies is really all I can do with that patient. If you're just sitting and doing compensatory strategies, you're not putting in all the skill that you can do, especially if you're doing them over and over and over again. And we're gonna go into that in some of these examples next. So when risk meets practice, you have to make sure when you're practicing that you are, again, representing the code that you are putting down. And you have to make sure that you are representing skilled therapy, reasonable and necessary.

So I wanted to look at some case examples. I'm going to go through each of these. I'm not gonna read them all on this slide. We're gonna to move through each of these examples. But these were actual examples that I pulled from different patient charts. And we're gonna go through and see how either what was done was not clearly represented, or was there actual skill involved? Were we actually doing something for this patient that would be considered skilled, number one? Would it be considered treatment at all? Or would it be considered something that either a non-skilled healthcare provider could have completed? Or is it something that could be considered assessment versus treatment? Okay, none of them are skilled therapy, just as a FYI.

Okay, so for example number one, this was originally what was written. Patient was seen bedside with spouse present. Trials of thin liquid provided. Patient observed to cough with thin liquids times six out of 10. Now, at first glance, when I'm looking at that, you could say, oh, well, that's a nice objective measurement, right? But what does that really mean, okay? What is that telling us? With verbal cues to utilize chin tuck, patient tolerated thin liquids without cough on nine out of 10 trials. I'm gonna take a pause here, okay. Tolerated. Let's just talk about the T word, right. I tolerate peppers. I don't love them. I tolerate them. I tolerate my husband leaving his dirty socks all over the place, okay, 'cause I love him. I tolerate it. Tolerating is a subjective term. So make

sure in your documentation, you're not using the word tolerated. It does not tell any skill as to what you have done. It doesn't say anything as to what the patient has done. And all it really says when you look at that word in a sentence, it says, I sat back and watched and did nothing. Okay. There was nothing to do. I didn't know how to, there's nothing to do, 'cause it's subjective. So stay away from the T word. But if we look at this, this was actually a second visit with a patient.

Okay, the patient was a status post CVA. There was no instrumental provided. There was a follow-up with the patient and wife the next day after this specific example was written. The patient and the wife were unable to recall that education. So in the last line here on top, this last line right here, where it says, "Education provided to patient and wife," regarding the continuous use of that chin-tuck strategy, the patient and the wife couldn't recall the education. So what specific education was provided? How was that skilled? Why couldn't somebody else provide that education? Why couldn't the doctor provide the education? Why couldn't the patient care assistant provide that education? What was skilled in regards to the education provided? And what was the response to the education? Did the patient and the wife verbalize understanding? Were they able to return, demonstrate what they learned? And then furthermore, there was an unclear rational of the chin tuck.

So if you're gonna use a strategy, don't just say that you're using a strategy. Because again, that looks like you're just hangin' out and watching the patient use a strategy. It doesn't take skill to say, hey, tuck your chin. Hey, remember to tuck your chin. Hey, did you tuck your chin? That's not skill. If you can present a rationale for a chin tuck or whatever compensatory strategy you're using, then you are beginning to demonstrate some skill, even more so if you can demonstrate not only the rationale but how you took that rationale and implemented it. Of note, the instrumental that was completed with this patient three days later demonstrated an increased silent aspiration of thins with chin tuck. So you know, there's that. Be careful with the chin tuck if you aren't

using that under fluoro. Okay, example two, patient seen during lunch. Patient noted to have good intake of chicken, yogurt, and thin liquids. Now, we're gonna stop again. Good, just like tolerate. It's a G word like a T word. Adequate is another one, okay. Those are all very subjective. Stay away from those terms. It leads to a risk of, hey, I don't know really what to write. I didn't really do any skill. The patient had good intake. Good intake could be a dietary thing, right. Nutrition, registered dietician can come in and say they had good intake of chicken, yogurt, and thin liquids. A patient care assistant can say good intake, because they went in a got the tray. That's not skilled. No overt signs and symptoms of aspiration noted. Patient with good rate of intake. Oh, there we go again. Recommend continue with current diet and discharge from speech therapy.

Okay, so again, this kind of looks like an assessment, right, to me, a little bit. But here's a backstory. The patient was actually evaluated on 12/15. The MBS was completed on 12/24. So not really sure what happened between 12/15 and 12/24, why the patient wasn't seen for any other instance or why the MBS was recommended. There was really no reason in the chart. Recommendation was regular solids and thin liquids on 12/24. There was impaired timing of the vocal cord closure, resulting bolus entry to the level of the cords on 50% of the trials. But they were effectively cleared. The patient was then seen for follow-up treatments, and each of those sessions was billed 92526, five more times, 12/26, 12/28, 12/29, 12/30, and 1/1. Just remember, reasonable and necessary means reasonable and necessary in frequency and duration.

The patient was recommended for thin liquids and regular solids and was seen five times after that. The notes for each of those follow-up sessions read just as this. It was as repetitive as you could get. Patient seen during mealtime. Patient with good intake on prescribed diet. Minimal throat clear. Patient appears to have fast-rate intake. No signs and symptoms of aspiration. Copy, paste, copy, paste. Non-skilled treatment would be routine, repetitive and reinforcing procedures. That's the definition of

non-skilled. And that couldn't be more of a clear example from this one. But how many times have we seen this, or maybe done it, right? So we wanna make sure that we're getting away from this practice. What did we do with the patient? How was it skilled? How did we improve their swallowing? If we look at this one, patient seen with breakfast tray, oral-motor exam completed. Labial/lingual strength appear within functional limits. PO trials provided. And it lists all the consistencies. It says the patient's reduced mastication of soft solids. Adequate, there's our A word, adequate bolus prep. Throat clear, no evidence of difficulty, and recommend downgrade. Is this evaluation or treatment?

'Cause I look at this, and I say, well, they just basically reassessed the patient. But they charged 92526. So what are we doing? First of all, it only says what the patient did. It only says what you, this is a clear example of, I observed the patient. Right? I see no skill in this note. And unfortunately, this note is something that was written. Okay. And 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. I'm not gonna read the whole thing, okay. But let's break this down just a little bit. Oral-motor exercises provided. Why? Okay, so it's telling us, yes, there is something that we did.

And it was active, and we didn't just watch the patient. But we need to talk about our rationale as to why. Adequate lingual protrusion and resistance to tongue depressor improved from previous session. How do we know that? Base-of-tongue exercises, okay, but which ones? And what does provided mean? Did you teach how to do it? Did you provide written instructions? Because if you're providing written instructions and just saying, okay, do this, that's as risky as just sittin' back and watching the patient eat. And then how are you testing the accuracy? And patient utilized effortful swallow and double-swallow during meals 93% of the time as measured by palpation. So is that really what we're, is that an adequate measurement? So here, the person was

trying to get closer to the mark. But we still need to make sure we're documenting skill. All right, and so with that, I'm makin' it just at the hour mark. I apologize, I know that we have hit the hour. But I do wanna give a couple minutes for questions. Thank you so much for attending this. The bottom line with all of this, everybody, is that we want to make sure that our services are clearly of a level of complexity and sophistication, that they're reasonable and necessary. And each time you are seeing a patient, each time you are writing your note, think of your skill. Think of what you want the patient to be doing. And think about how we are making sure that we are not just sitting and observing if we are charging a code for treatment and how we are moving our patient to the right direction improving their swallowing. Sorry, Amy, with that, I'll take questions.

- [Amy] Thank you, Katie. I did wanna just let our participants know, if you need to go now, you will have credit for having attended the entire thing. But if you have a couple of minutes to stick around for some Q and A, please do that. There's a question here that asks, is the 3-ounce water swallow screening the same as the Yale?

- [Katie] Yes, I use them interchangeably.

- [Amy] Okay, that's what I was thinking. There's a question here from Susan. You know what, I'm gonna expand this box for myself. Can you please clarify the time component of service-based CPT codes? She was not clear on what you were saying about minimum or maximum sum of time.

- [Katie] Yeah, so an untimed service code, in contrast to a time code, a time code usually is a 15-minute code. But there are timed codes that are 60 minutes or other things. The time codes are pretty self-explanatory, right. They have a time associated with them. With the service codes, even though they are untimed, meaning that you can see the patient for an unlimited amount of time, basically, you still have to be able

to, there's a built-in time for each code. And I don't have the number, the exact time for each code, the time built in. But there is a time built in, and you can go to your CPT manual and look at that. I believe it's available online. But the point of that statement is really just to say, you can't see the patient for three minutes and say, hey, I'm done. That would not be an adequate, just because it's service-based and there's no time attached to it, that doesn't mean it's a free-for-all. That's really the point of that slide, is to make sure that everybody's aware of the fact that service-based or non-timed doesn't mean untimed or no time at all.

- [Amy] Got it. We had a couple people asking, and I believe I remember what you said about this. There are a couple people that were wondering about, I believe this is from the exam, but about non-swallowing exercises that have high-quality evidence. And you said that Shaker does have good evidence.

- That's correct.

- Is that correct?

- Shaker does have good evidence behind it, yes. It is, if I can, let's see if I can find, really quickly, where that came from. I have a reference on that. But the Shaker's is one of the ones that has the highest reliability with that.

- [Amy] Okay, good. Here's one here that sounds familiar. "So with regard to nursing screens, in my facility, "the nurses are actually documented as doing evals. "They overstep boundaries, "often jump in to eval the patient "before we get downstairs to complete it ourselves. "Legally, we have 24 hours to respond. "And we always respond within the same day." But any thoughts about, and she said, "So what's our purpose, if RNs are kind of "taking over feeding"--

- Oh, okay, so--

- [Amy] "And completing swallowing evaluations?"

- [Katie] Yes, so I will say, first of all, our purpose, number one, is to make sure that we are advocating for our profession. And I'm not taking anything away from nurses. Some of my best friends are nurses. I've worked with excellent nurses. But my nurses that are my friends will be the first ones to say, "We don't know everything about swallowing. "And we certainly don't know "as much as speech pathologists." And yes, I mean, it is common. Part of it is the order set that's built into these electronic systems, where there's an order set that says screen, and then evaluate, or the documentation language says evaluation completed when it was supposed to be screening. So it is kind of just a byproduct of an issue that occurs with those documentation order sets. But our role is really, number one, we have to advocate for our profession. We are highly skilled, trained professionals. We have expertise. Some of use have board certification in swallowing. It's something that we need to take some pride in and use it as an education to everyone to say, hey, this is what we know. This is what we can provide to the patient. And even more so, this is why it's really important for us not to just go in, assess, look back, and document that we provided a session. This is where we really need to be seen as providers who are providing therapy, if that makes sense.

- [Amy] I'm gonna just ask one more question here, because there was two or three people that had questions along the same line. And it has to do with, so you have a patient who's been on a particular diet. Say they've been on a puree. And you want to see if they can be upgraded. And so is that going to be a reassessment? Or how do you see if it's time for them to be upgraded? And then once you upgrade them, I won't use the T word, but if they are-- To make sure they are not exhibiting any signs and symptoms of difficulties with that diet upgrade.

- [Katie] Yeah, so I think this is where our conundrum is, and we run into this a lot, where we feel like we have to constantly upgrade our patients. And it comes from a good place. Nobody wants to be on puree and honey thick. They just don't. So we wanna try to get them off as soon as possible. But I would say, number one, if you're reassessing the patient, you're reassessing the patient. And you need to make sure you're stating that it's a reassessment and not a treatment. There is a component of diagnostic treatment that kind of falls into what we do. But I guess my personal opinion is that I feel like so many of us, as a field, we get into this habit of constantly assessing. And if that's all you're doing during the session, you're not doing treatment. You're just not. So yes, there is a point where you're going to need to reassess your patient. I think that that's valid. But again, go back to the definition of skilled and reasonable and necessary. What is the frequency and duration? If you're reassessing every day, or even once a week, that's probably not reasonable and necessary. You need to give that patient time to rehabilitate their swallow. So think about how often you're doing this, and is that realistic? If you're reassessing at an interval that is reasonable and necessary, then I think a reassessment is expected and would be considered skilled at that time.

- [Amy] Great, well, thank you so much. I'm gonna go ahead and wrap it up here. I imagine we could talk about this for a good while longer, but I want to let everybody get back to their clients or patients.

- Absolutely.

- [Amy] Thanks to our audience for being here and for some great questions. Thanks so much, Katie. We love it when you come in to talk to use, and some great information today. I'd like to thank you for being willing to present for us.

- [Katie] Thank you so much. I had a great time, as always.

- [Amy] All right, everybody, we're gonna wrap it up here. Hope we see you again in a webinar before too long. Bye.

- [Katie] Thanks.