Dysphagia in Motion
South Louisiana Swallowing Diagnostics

FAQS ABOUT INSTRUMENTAL SWALLOW STUDIES

How common is dysphagia?

- The prevalence of dysphagia has been estimated to be as high as 68% of all residents in long term care facilities. (Steele, 1997)
- It is estimated that over 45% of patients residing in nursing homes with dementia suffer from dysphagia. (Sura, 2012)
- 50-75% of stroke patients develop dysphagia, with silent aspiration occurring 50% of the time. (Horner, 1988)
- In patients who were intubated 48+ hours with Acute Respiratory Failure: 56% have dysphagia and 50% aspirate. At least 44% of all aspiration is silent in this population. (Ajemian et al., 2001)
- Intubation injuries occur in 88% of intubated patients (46% were severe) raising risk of dysphagia and aspiration. (Estelle-More et al., 2005)

Why do SLPs need instrumental swallow studies like FEES or MBSS in the skilled nursing and rehab settings?

- Researchers did an analysis of over 150 articles on the Clinical Swallow Exam (CSE) and concluded that that while there was some limited data that supports the use of CSE measures to detect aspiration post-stroke, no data existed to support the use of the CSE to evaluate any of the physiologic measures deemed necessary for complete examination of swallowing function. (McCullough et al. 2003)
- When comparing a non-instrumental based assessment with that of an instrumental, the false positive rate for the Clinical Swallow Exam was 70% - which means 70% of the time SLPs are over-diagnosing swallowing disorders that do not exist leading to overly restrictive diets and potential dehydration and malnutrition. There is a 14% false negative rate, meaning silent aspiration is completely missed at the bedside 14% of the time. (Leder, 2002).

What is FEES?

Flexible Endoscopic Evaluation of Swallowing (FEES) is an instrumental exam that has been used to evaluate swallowing at the bedside since 1988. It is an alternative to the Modified Barium Swallow Study (MBSS) completed in the radiology department at the hospital.

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Why didn't the patient get an instrumental exam in the hospital prior to discharge?

The patient may not have had a VFSS done in the hospital for a few reasons:

- Staffing - There may not have been a trained SLP available to perform the study.
- Radiology limitations - The radiology suite may be completely booked for the day of the exam.
- Weekend or immediate discharges - Some hospitals make their best efforts to reduce lengths of stays. The patient may be discharged as soon as they are deemed stable, even if they had orders for an instrumental exam to be performed.

What costs are associated with dysphagia that may affect my facility?

- Patients have a tendency to find thickened liquids not as palatable, therefore drinking much less than if it were a thinner consistency, leading to potential dehydration. (Daniels and Huckabee, 2014)
- Thickened liquids have been directly linked to dehydration, electrolyte imbalance, and UTIs due to the decreased palatability leading to resident refusal.
- The following five conditions - congestive heart failure (CHF), upper respiratory infections (URI), urinary tract infections (UTI), sepsis, and electrolyte imbalance -all account for 78% of all 30-day SNF re-hospitalizations, and have all been deemed as potentially avoidable with careful monitoring of and adherence to patient fluid and nutrient intake, and by following appropriate positioning of residents with swallowing problems to avoid aspiration that could lead to pneumonia. (Mor et. al, 2010)
- The cost to keep 1 resident on thickened liquids for 1 year can cost your facility between $2,000-$7,000 annually.
- The cost of managing a patient with a feeding tube, which for many has been the primary treatment option for dysphagia is reported to average over $31,000 per patient per year, with 70% of patient's reporting serious medical complications. (Hwang et al., 2014)
- Aspiration pneumonia is the leading cause of death and the most common complication arising from dysphagia for long term care residents. (Oh et al., 2004)

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How much does an instrumental exam cost for a Part A resident?

The cost for a hospital MBSS ranges between $1,000-$1,800, with the average rate in South Louisiana being around $1,100. Transportation can amount to about half this cost, in addition to radiology charges.

The cost for a mobile FEES ranges between $300-$600, with the average rate in South Louisiana being around $400. We charge a flat rate and there are no transportation costs associated with our services.

How much does an instrumental exam cost for a Part B resident?

With Part B, the radiology portion can be directly billed from the hospital right to Medicare. The facility pays for 80% of the transportations costs, the family pays 20%. Speech charges from the hospital are also billed to the facility seperately.

Can the mobile FEES/MBSS companies bill insurance?

No, because patients who reside in Skilled Nursing and Inpatient Rehab Facilities are subject to CMS Consolidated Billing Regulations. Since FEES/MBSS exams conducted by an SLP falls under SPEECH THERAPY codes, the facility is responsible for them.

My facility doesn't want to be in an exclusive contract.

It's illegal per Centers for Medicare & Medicaid Services (CMS) guidelines to be locked in to a long-term, exclusive contract with a diagnostic company. SLPs are responsible for making the most clinically appropriate recommendation for your patient whether it be a mobile service or MBSS at the hospital.

Our service agreement is a non-exclusive and non-binding with no minimums to meet - this means the facility is still welcome to send anyone to the hospital for MBSS if needed

The rehab company that I work for is contracted out by the facility. Who pays for the swallow study in that case?

If you work for a rehab company that is SEPARATE from the skilled nursing facility, just be aware that the Consolidated Billing guidelines from CMS apply to the facility, so the FACILITY will be responsible for paying for the swallow studies, not your rehab company.

What are the American Speech-Language and Hearing Association (ASHA) guidelines about instrumentals exams?

This section is taken directly from the "Clinical Indicators for Instrumental Assessment of Dysphagia" site. These guidelines are an official statement of the American Speech-Language-Hearing Association (ASHA):

A. An instrumental examination is indicated for making the diagnosis and/or planning effective management and treatment in patients with suspected, or who are at high risk for, oropharyngeal dysphagia based on the clinical examination when:

• The patient's signs and symptoms are inconsistent with findings on the clinical examination.

• There is a need to confirm a suspected medical diagnosis and/or assist in the determination of a differential medical diagnosis.

• Confirmation and/or differential diagnosis of the dysphagia is needed.

• There is either nutritional or pulmonary compromise and a question of whether the oropharyngeal dysphagia is contributing to these conditions.

• The safety and efficiency of the swallow remains a concern.

• The patient is identified as a swallow rehabilitation candidate and specific information is needed to guide management and treatment.

B. An instrumental examination may be indicated [*] for making the diagnosis and/or planning effective treatment in patients with suspected dysphagia based on the clinical examination and the presence of one or more of the following:

• The patient has a medical condition or diagnosis associated with a high risk for dysphagia, including but not limited to neurologic, pulmonary or cardiopulmonary, gastrointestinal problems; immune system compromise; surgery and/or radiotherapy to the head and neck; and craniofacial abnormalities.

• The patient has a previously diagnosed dysphagia and a change in swallow function is suspected.

• The patient has a condition such as cognitive or communication deficits that preclude completion of a valid clinical examination.

• The patient has a chronic degenerative disease or a disease with a known progression, or is in a stable or recovering condition for which oropharyngeal function may require further definition for management.

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WHEN TO ORDER FEES VS MBSS

Adapted from: Langmore, S.E. (2006). Endoscopic evaluation and pharyngeal phases of swallowing. GI Motility Online.

	MBSS	FEES	EITHER
Vague symptoms	X		
Globus sensation			X
Esophageal concerns	X		
Assess oral phase only	X		
Unable to transport		X	
Assess secretion management		X	
Examine surface anatomy		X	
Dysphagia w/ dysphonia		X	
History or suspected vocal fold paresis/paralysis		X	
Extended exam time		X	
Therapeutic maneuver training (biofeedback)		X	
Post-intubation		X	
Tracheotomy		X	
Wet vocal quality		X	
Laryngectomy complications	X		
Tracheoesophagel (TE) fistula	X - primary		X

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