Speech and Swallowing Specialists of Arkansas
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Facts sheet

Benefits of Mobile Fiberoptic Endoscopic Evaluation of Swallowing (FEES) in a COVID 19 World

- Why Are Instrumental Assessments So Important for SLPs and Patients?
  - Allows us to view anatomy and physiology
  - We can determine the pathophysiology of the swallow
  - We can establish an accurate, evidence-based and concise plan of care
  - We can perform in the comfort of a patient's home or living facility (without sending to the hospitals, decreasing exposure to illness)
  - Clinical swallow evaluations (CSE) do not provide enough of the information needed to assess swallow function (CPT code 92610)
    - (this is our initial evaluation serving to determine if we believe a patient is at risk for aspiration/dysphagia, it acts as an assessment or screen to determine if a patient needs an instrumental or not)
    - This CSE cannot give us adequate information to make a treatment plan for pharyngeal dysphagia! (We don't have X-ray vision; we can't treat what we can't see)
- In a subcommittee report based on review of over 150 articles, McCullough et al. (2003) reported that **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.**
  - "If the clinical (bedside) evaluation does not provide sufficient information to allow for confident patient management, an instrumental assessment should be performed" (Leder & Murray, 2008, p. 788).
- Dysphagia causes patients to have difficulty eating and drinking. What happens when you don't drink enough fluids? **The patient is at increased risk for dehydration, malnutrition, electrolyte imbalance, sepsis, and/or a UTI.** (Richard, 2018, slide 29)
  - All 5 of those conditions equate for 78% of all 30-day re-hospitalizations. (Mor et. al, 2010)
- At the bedside, without any sort of instrumental, SLPs are **over diagnosing dysphagia 70% of the time**, using clinical signs and symptoms to create a diagnosis that doesn't exist (Leder, 2002). SLPs are also **missing SILENT aspiration at the bedside 14% of the time** (Leder, 2002).
  - Why should it matter if we miss silent aspiration?
    - Well for starters, aspiration pneumonia is the leading cause of death in SNFs, and residents that are diagnosed with aspiration pneumonia have a mortality rate three times higher than the other residents (Oh et al., 2004).

Safety of FEES during COVID

- (American Academy of Otolaryngology - Head and Neck Surgery, 2020)

Nasal endoscopy and flexible nasal laryngoscopy in and of itself are presumably not AGPs. However, they may potentially increase the likelihood of cough, gag, and sneeze, with possible subsequent aerosolization, and therefore appropriate precautions should be considered based on individual clinical circumstances.

There are theoretical concerns of increased risk of transmission of COVID-19 infection when interventions involving the pharyngeal mucosa and the respiratory tract potentially cause aerosol generation in an actively infected individual. To date, there is no definitive evidence of transmission associated with specific otolaryngologic procedures. Although there is a published anecdotal report that suggested the theory that a high-speed drill may have caused transmission to healthcare workers during a pituitary surgery, this report was subsequently refuted by the primary surgical team who attributed all healthcare worker COVID-19 transmission to non-surgical care provided by staff who were not wearing appropriate PPE.

Suggested Minimal PPE

COVID Testing Status	Instrumentation	Intervention disrupting respiratory mucosa	Suggested Minimal PPE
Positive	Any	Any	N95 or PAPR; eye protection, gloves, gown
Unknown	Any	Yes	N95 or PAPR; eye protection, gloves
Unknown	Potential aerosol generating instrumentation/thermal	No	N95 or PAPR; eye protection, gloves
Negative*	Any	Yes	* N95 or PAPR; eye protection, gloves
Negative*	Potential aerosol generating instrumentation/thermal	No	* N95 or PAPR; eye protection, gloves
Unknown/Negative	Non-potential aerosol generating instrumentation/Non-thermal	No	Surgical mask, eye protection. gloves

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Moving Forward with Dysphagia Care: Implementing Strategies during the COVID-19 Pandemic and Beyond

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FEES has been suggested as an alternative for VFSS for patients in long-term care settings. While some have advised endoscopy should be discontinued due to concerns for increased risk of spread of SARS-CoV-2, the suggestion that VFSS is the only option for instrumental assessment of swallowing for patients puts strain on nursing home/home health administrators when they cannot get their residents access at this time. The result is many patients needing testing are waiting in limbo, lengths of stay are prolonged, and healthcare costs increase.

To reduce risk to patients and clinicians (see Fig. 2), clinicians performing FEES are advised to don full PPE, including N95 masks, face shields, gowns, and gloves, even in facilities without any positive cases, as there is still a risk for community spread, especially in this setting. As a general rule, nursing care facilities do not stock large quantities of PPE. Pre-COVID-19, most residents who develop transmissible disease were sent to the hospital for care. Access to PPE should be considered prior to intervention.

- Let's talk about imaging
  - CXR, MRI, CT scans are" high cost", however, those are still required for medical professionals to treat appropriately.
  - Unnecessary therapy is "high cost" for our patients, too
  - If we continue to discuss or give in to cost discussions vs. what we know about required instrumental assessments to determine physiological function, others will continue to expect us as SLPs to make recommendations without appropriate testing
  - We are PATHOLOGISTS and proper imaging is needed for us to DIAGNOSE dysphagia.
- Benefits of Mobile FEES
  - Most studies are performed within 1-2 days of referral (with obtained physician order)
  - Decreased transportation costs - patient remains in the facility
  - Full-color report and video are provided the same day
  - Treating SLP gets to collaborate in the assessment (and can bill for treatment once scope is out of the nose)
  - Real food/liquid is tested (no barium) -we bring food trails and our own PPE-
  - No radiation exposure means longer & more thorough assessments can be performed
  - FEES is able to detect structural/functional abnormalities of the vocal folds such as lesions, laryngeal injuries, edema, vocal fold paralysis, and more. These are common following prolonged COVID-19 intubation.
- The cost of FEES instrumental vs…..
  - Cost of being re-hospitalized
    - A re-hospitalization due to aspiration pneumonia costs about $30,000.
  - Risk of aspiration/malnourishment leading to other issues
    - "We can't afford/they don't matter/ we don't have time to get instrumentals, we'll just put them on thickened liquids and they'll be fine." (Richard, 2018, slide 25)
      - Miles et al. (2018) tells us that patients may be more likely to silently aspirate thickened liquids than thin liquids. (This is why getting that instrumental assessment is so important!)
    - Nativ-Zeltzer et al. (2018) tells us that:
      - Aspiration of thickener can lead to pulmonary injury and aspiration of modified cornstarch thickener is worse on lung tissues than aspiration of xanthan gum thickener and aspiration of xanthan gum is worse than aspiration of plain water
    - Robbins et al. (2008) tells us that there is an increased risk of aspiration pneumonia development with use of honey thickened liquids.
    - Thickened liquids are hard to drink. **Again, this puts the patient at increased risk for dehydration, malnutrition, electrolyte imbalance, sepsis, and/or a UTI.** (Richard, 2018, slide 29). All 5 of those conditions equate for **78% of all 30 day re-hospitalizations.** (Mor et. al, 2010)
  - Cost of PEG tube management and thickened liquids for facility
    - One resident on thickened liquid for a year can cost a facility between $2,000-$7,000 (Richard, 2018)
    - PEG tube management costs $31,000+ per year (Hwang et. al, 2015)
  - Cost of MBSS vs cost of FEES
    - Additionally, **the cost of a Mobile FEES procedure is about 1/4 of the cost** of a hospital MBSS. (Adapted from Richard, 2018)
- Think, if a 120-bed facility went from 22 patients on thickened liquids and PEG tubes to 2.
  - Wouldn't it be more cost effective to get instrumentals for patients and rule out over-diagnosed dysphagia than continue to pay for unnecessary accommodations?
  - Think about how this would also improve patient quality of life
- SNF rules on cost
  - Both part A and part B billing for therapy services fall under consolidated billing in a SNF. It is illegal for an outside therapy provider to bill on their own in a SNF. The facility is billed by the FEES provider, and then the SNF is responsible for submitting billing for any reimbursement under both A and B (CPT code 92612 for FEES)
    - https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling

See MLN Matters Special Edition article SE0431 for a detailed overview of SNF consolidated billing, including a section on services excluded from SNF consolidated billing. This article can be found at **http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0431.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

The law specifically provides that physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services are not excluded from consolidated billing (Section 1888(e)(2)(A)(ii) of the Social Security Act and regulations at 42 CFR 411.15(p)(1)(i)). (References in this article to therapy cover only PT, OT, and SLP services.)

The consolidated billing legislation is very emphatic that PT, OT, and SLP services furnished to SNF residents are always subject to consolidated billing. This applies even when a resident receives the therapy during a non-covered stay in which a beneficiary who is not eligible for Part A extended care benefits still resides in an institution (or part thereof) that is Medicare-certified as a SNF. The legislation also applies regardless of whether or not the services are performed by, or under the supervision of, a practitioner (such as a physician) whose services would otherwise be excluded from consolidated billing.

Therapy services that are furnished to residents of a Medicare-certified SNF are subject to the SNF consolidated billing provision. Payment for therapy services furnished during a covered Part A stay is included in the SNF's global per diem PPS rate.

In a non-covered SNF stay, the beneficiary may be eligible for coverage of individual medical and other health services under Part B. Since the beneficiary still resides in a Medicare-certified institution (or part thereof) the therapy services are subject to the SNF consolidated billing provision. Under this provision, the

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claims for therapy services furnished during a non-covered SNF stay must be submitted to Medicare by the SNF itself. The SNF is responsible for reimbursing the provider. The SNF would bill its fiscal intermediary and be reimbursed under the Medicare fee schedule.

When a beneficiary resides in a nursing home (or part thereof) that is not certified as an SNF by Medicare, the Part A extended care benefit cannot cover the beneficiary's stay. However, the beneficiary may still be eligible for Part B coverage of certain individual services, including therapy. In this case, the beneficiary is not considered an SNF resident for Medicare billing purposes, and the therapy services are not subject to consolidated billing. Either the therapy provider or the facility may bill the Medicare carrier for Part B directly.

Additional Information

See MLN Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0431.pdf on the CMS website.

The CMS MLN Consolidated Billing information can be found at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html on the CMS website.

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing information can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html on the CMS website.