Screening for Dysphagia

This measure is to be reported for all patients aged 18 years and older undergoing active treatment for ischemic stroke or intracranial hemorrhage for each hospital stay during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

Measure description
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who receive any foods, fluids, or medication by mouth (PO) for whom a dysphagia screening1 was performed prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care.

What will you need to report for each hospital stay for patients under active treatment for ischemic stroke or intracranial hemorrhage for this measure?
If you select this measure for reporting, you will report:

- Whether or not the patient is receiving or is eligible to receive food, fluids, or medication by mouth2 (PO)

If the patient is receiving or eligible to receive food, fluids, or medication by mouth (PO), you will then need to report:

- Whether or not you performed a dysphagia screening prior to order or receipt of any foods, fluids or medications by mouth

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to conduct dysphagia screening prior to the order for or the patient’s receipt of any foods, fluids or medication by mouth, due to:

- Medical reasons (e.g., not indicated, contraindicated, other medical reason[s]) OR
- Patient reasons (e.g., patient left against medical advice, other patient reason[s])

In these cases, you will need to indicate that the medical reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).

1Dysphagia screening may include, but is not limited to videofluoroscopic swallow evaluation (VSE), fiberoptic endoscopic evaluation of swallowing (FEES), modified barium swallow, structured bedside swallowing assessment.

2For purposes of this measure, patients “who receive any food, fluids or medication by mouth” may be identified by the absence of an NPO (nothing by mouth) order.
Coding Specifications

Codes required to document patient has ischemic stroke or intracranial hemorrhage and a visit occurred:

An ICD-9-CM diagnosis code for ischemic stroke or intracranial hemorrhage and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Ischemic stroke or intracranial hemorrhage
ICD-9-CM diagnosis codes
- 430 (subarachnoid hemorrhage)
- 431 (intracerebral hemorrhage)
- 432.0, 432.1, 432.9 (unspecified intracranial hemorrhage)
- 433.01, 433.11, 433.21, 433.31, 433.81, 433.91 (occlusion and stenosis of cerebral arteries)
- 434.01, 434.11, 434.91 (occlusion of cerebral arteries)

AND

CPT codes
- 99218, 99219, 99220
- 99221, 99222, 99223
- 99234, 99235, 99236
- 99281, 99282, 99283, 99284, 2985
- 99291

Quality codes for this measure:

CPT II code descriptors
(Data collection sheet should be used to determine appropriate code or combination of codes.)
- **CPT II 6015F**: Patient receiving or eligible to receive food, fluids or medication by mouth
- **CPT II 6020F**: NPO (nothing by mouth) ordered
- **CPT II 6010F**: Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth
- **CPT II 6010F–1P**: Documentation of medical reason(s) for not conducting a dysphagia screening prior to taking any foods, fluids or medication by mouth (eg, patient expired during inpatient stay, patient without any focal findings and not thought to be having a stroke when initially evaluated, other medical reason(s))
- **CPT II 6010F–2P**: Documentation of patient reasons(s) for not conducting a dysphagia screening prior to taking any foods, fluids or medication by mouth (eg, patient left against medical advice, other patient reason(s))
- **CPT II 6010F–8P**: Dysphagia screening was not conducted prior to order for or receipt of any foods, fluids or medication by mouth, reason not otherwise specified
# Screening for Dysphagia

## Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>

National Provider Identifier (NPI) | Date of Service

### Clinical Information

#### Step 1 Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Is patient is aged 18 years and older on date of encounter.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient has a diagnosis of ischemic stroke or intracranial hemorrhage.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>There is a CPT code for this visit.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. Do not report a CPT category II code.

#### Step 2 Does patient also have the other requirements for this measure?

<table>
<thead>
<tr>
<th>Is the patient receiving or eligible to receive food, fluids, or medication by mouth (PO)?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If No (ie, NPO [nothing by mouth] ordered), report only 6020F and STOP.

If Yes, report 6015F and proceed to Step 3.

#### Step 3 Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Dysphagia Screening* prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducted</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Not conducted for the following reason:

- Medical (eg, patient expired during inpatient stay, patient without any focal findings and not thought to be having a stroke when initially evaluated, other medical reason(s))
  - Yes | No | 6010F–1P

- Patient (eg, patient left against medical advice, other patient reason(s))
  - Yes | No | 6010F–2P

Document reason here and in medical chart.

If No is checked for all of the above, report 6010F–8P (Dysphagia screening was not conducted prior to order for or receipt of any foods, fluids or medication by mouth (PO), reason not otherwise specified)

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*For purposes of this measure, patients “who receive any food, fluids or medication by mouth” may be identified by the absence of an NPO (nothing by mouth) order.

*2Dysphagia screening may include, but is not limited to videofluoroscopic swallow evaluation (VSE), fiberoptic endoscopic evaluation of swallowing (FEES), modified barium swallow, structured bedside swallowing assessment.