1 Patient Information

1 PATIENT DETAILS

Name
Eleanor J. Sutton

Date of Service
05/06/2026

DOB
04/18/1950

Provider
Dr. Linda A. Park, MD — Otolaryngology / Head & Neck Surgery

Age / Sex
76 / Female

MRN
ENT-2026-1024

Visit Type
Dysphagia Evaluation — Initial Consultation

Referral Source
Dr. Omar Farouk, MD — Neurology (inpatient consult at discharge)

Primary Concern
Difficulty swallowing solids and liquids — aspiration concern post-stroke

CC Chief Complaint

2 PRIMARY SWALLOWING-RELATED CONCERN

Mrs. Sutton is a 76-year-old female presenting for outpatient dysphagia evaluation 6 weeks after a left middle cerebral artery (MCA) ischemic stroke. She was discharged from acute rehabilitation 2 weeks ago on a pureed diet with thickened liquids (IDDSI Level 4 / Nectar-thick). She states: 'I've always loved eating and now I choke on everything. Even thickened liquids go down wrong sometimes. I've lost 18 pounds and I'm miserable. My daughter says I sound wet after I eat.' She has had 2 episodes of aspiration pneumonia since the stroke (one during hospitalization, one post-discharge requiring re-admission 10 days ago). She is currently on a pureed diet + nectar-thick liquids with aspiration precautions per inpatient SLP recommendation. She has a nasogastric tube (NGT) that was placed during the second pneumonia admission and remains in place — providing 60% of her caloric needs.

S Subjective

3 PATIENT-REPORTED SWALLOWING SYMPTOMS & HISTORY

3a SYMPTOM ONSET & COURSE

Dysphagia onset: immediately following left MCA ischemic stroke (03/22/2026). Stroke presentation: sudden right-sided weakness, right facial droop, dysarthria, and dysphagia. Admitted to hospital 03/22/2026, thrombolysis (tPA) administered, transferred to stroke unit. Bedside swallow evaluation in hospital: FAILED — aspiration of thin liquids on clinical exam. Modified diet initiated. NGT placed for nutritional support during first hospitalization. Transferred to inpatient acute rehabilitation 04/05/2026. Discharged from rehab 04/22/2026. Second hospitalization (04/25–05/02/2026): aspiration pneumonia — right lower lobe consolidation. NGT re-placed during second hospitalization. Dysphagia has improved since acute stroke but remains clinically significant with clear ongoing aspiration risk on current diet.

3b SWALLOWING PATTERN

SOLIDS: Cannot manage solid foods — pureed only (IDDSI Level 4). Attempts at soft foods have resulted in coughing episodes. LIQUIDS: Thin liquids cause immediate coughing and choking — confirmed failure in hospital. Currently on nectar-thick liquids (IDDSI Level 2) per rehab SLP recommendation — occasional coughing even with thickened liquids (2–3 episodes/day). PILLS: Currently crushing all medications in applesauce — unable to swallow whole tablets. PHASE: Both oral and pharyngeal phase dysfunction suspected — oral preparatory difficulty (right facial weakness causing right-side buccal pocketing) AND pharyngeal phase dysfunction (delayed swallow trigger, reduced pharyngeal clearing, aspiration before and during swallow from neurogenic dysfunction).

3c ASSOCIATED SWALLOWING SYMPTOMS

COUGHING WITH MEALS: Frequent — 3–6 coughing episodes per meal with thickened liquids; worse with thin liquids. THROAT CLEARING: Constant — 'wet' voice noted by daughter after meals. WET/GURGLY VOICE: Present post-meal — resolved partially with dry swallows. FOOD POCKETING: Right buccal pocketing noticed by family (right facial weakness from stroke). GLOBUS SENSATION: Mild, constant — food 'sticking' sensation at the level of the upper chest (cricopharyngeal level suspected). REGURGITATION: No frank regurgitation. HEARTBURN: Moderate — history of LPR, currently on omeprazole 40 mg BID but not well-controlled per patient report. No frank hematemesis. DROOLING: Mild right-sided drooling (right facial weakness).

3d VOICE / AIRWAY SYMPTOMS

VOICE: Dysarthric (from stroke) — slurred, right-sided facial droop affecting articulation. Wet/gurgly voice quality immediately post-swallow — resolves with throat clearing, returning with subsequent swallows. Hoarseness: mild. No stridor. No significant dyspnea at rest (SpO2 95% on room air today — borderline, has been 93% during second pneumonia hospitalization). Chronic cough: present since stroke — productive, particularly post-meal. No hemoptysis.

3e REFLUX / GI SYMPTOMS

HEARTBURN/REFLUX: Significant — rates heartburn 5/10 most days. Has history of laryngopharyngeal reflux (LPR) diagnosed 2022. On omeprazole 40 mg BID (standard twice-daily PPI regimen). Reflux symptoms not well-controlled — still having significant throat clearing and laryngeal irritation. This LPR component may be contributing to laryngeal mucosal sensitivity and compounding the neurogenic dysphagia. No nausea or vomiting. No hematemesis. No weight loss beyond what is attributed to dysphagia-reduced intake.

3f NEUROLOGIC / MEDICAL HISTORY

PRIMARY: Left MCA ischemic stroke (03/22/2026) — right hemiparesis (arm > leg), right central facial droop, mild right hemispatial neglect (improving), dysarthria. Anticoagulated with apixaban 5 mg BID for AF. Secondary: Atrial fibrillation (stroke mechanism — cardioembolic, CHADS2-VASc 6). Hypertension — metoprolol 25 mg BID + amlodipine 5 mg. T2DM — insulin glargine 20 units QHS + metformin 500 mg BID. Hypothyroidism — levothyroxine 75 mcg. Osteoporosis — alendronate (held due to dysphagia — cannot take upright x30 min per requirement). GERD/LPR — omeprazole 40 mg BID. Prior aspiration pneumonia x2 (during and post-stroke as above).

3g NUTRITIONAL / FUNCTIONAL IMPACT

WEIGHT LOSS: 18 lbs in 6 weeks (pre-stroke weight 142 lbs; today 124 lbs — severe malnutrition concern). BMI today: 20.2 (borderline underweight for age; was 22.5 pre-stroke). NUTRITIONAL INTAKE: NGT providing approximately 60% of nutritional needs; pureed oral diet providing 40% when she can eat without complications. Calorie goal per dietitian (reviewed): 1,600 kcal/day; current estimated intake 900–1,100 kcal/day. FEEDING TUBE STATUS: NGT in left nostril — placed during second pneumonia hospitalization. Patient and daughter requesting guidance on whether to proceed with PEG tube for longer-term enteral nutrition. ACTIVITY: Limited mobility from right hemiparesis — uses rollator for short distances. Attended outpatient PT and OT. QUALITY OF LIFE: Patient rates QOL as 3/10 — eating was a major life pleasure; social meals with family have become distressing and avoided.

3h PRIOR EVALUATION & TREATMENT

SWALLOWING EVALUATIONS: (1) Bedside swallow evaluation (hospital 03/22): Failed thin liquids — NGT placed. (2) Modified barium swallow (MBS, 04/02/2026, during hospitalization): Oral phase dysfunction from right facial weakness; reduced laryngeal elevation; silent aspiration of thin liquids; trace aspiration of nectar-thick; recommended pureed + nectar-thick. (3) Inpatient SLP (acute rehab, 04/05–04/22): Swallowing exercises (Shaker exercises, Masako maneuver, effortful swallow). Current diet: IDDSI Level 4 pureed + nectar-thick liquids. PRIOR GI EVALUATION: Esophagogastroduodenoscopy (EGD, 2022) for LPR — normal esophagus; no Barrett's; mild gastritis. No prior esophageal dilation or manometry. No prior formal ENT dysphagia evaluation.

3i PERTINENT NEGATIVES

No nasal regurgitation. No complete inability to manage own secretions (manages saliva with occasional difficulty). No hematemesis or hemoptysis. No new neurologic deficits since discharge. Fever: none today (afebrile). No significant weight loss beyond what is accounted for by dysphagia-related reduced intake. No neck mass or throat pain. No dysphonia beyond dysarthria from stroke.

ROS ENT / Swallowing Review of Systems

4 PERTINENT POSITIVES & NEGATIVES

- **Dysphagia to solids / liquids / pills:** POSITIVE — all three. Pureed + nectar-thick only; pills crushed
- **Globus / food sticking:** POSITIVE — globus at upper chest level (cricopharyngeal suspected)
- **Choking / coughing with meals:** POSITIVE — 3-6 episodes per meal; worse with thin liquids
- **Odynophagia:** Denied

- **Hoarseness / wet gurgly voice:** POSITIVE — wet voice post-swallow; dysarthria from stroke
- **Reflux / regurgitation / heartburn:** POSITIVE — LPR poorly controlled despite PPI BID
- **Neck mass / throat pain:** Denied
- **Chronic cough / aspiration:** POSITIVE — productive cough, 2x aspiration pneumonia post-stroke
- **Weight loss / reduced intake:** POSITIVE — 18 lbs in 6 weeks; NGT for supplemental nutrition
- **Neurologic symptoms / weakness:** POSITIVE — right hemiparesis, right facial droop from stroke (pre-existing, not new)

O Objective

5 SWALLOWING, AIRWAY & ENT FINDINGS

V VITAL SIGNS

Temperature
98.2°F

Blood Pressure
138/84 mmHg

Heart Rate
72 bpm (regular — AF well-controlled on apixaban)

Respiratory Rate
18 breaths/min

Oxygen Saturation
95% on room air — borderline; 93% during second pneumonia

Height / Weight
5'4" / 124 lbs (BMI 20.2) — down 18 lbs from 142 lbs pre-stroke

BMI
20.2 — borderline underweight; nutritional compromise

Pain Score
1/10 — mild throat discomfort

5a GENERAL APPEARANCE

Elderly thin female — visibly underweight compared to pre-stroke appearance per daughter's description. Right facial droop noted at rest — incomplete right lower facial paralysis (central pattern — UMN stroke). Mild dysarthria — slurred right-sided speech. NGT in left nostril, secured with tape. Right arm in sling (right upper extremity spastic hemiplegia). Ambulates with rollator with right-sided assistance. Alert, oriented x3. Cooperative and tearful when discussing food restriction.

5b HEAD & FACE / EARS / NOSE

Head & Face
Right central facial droop — lower face right > upper face. Right-sided labial seal incomplete (buccal pocketing risk). Left facial function: intact. No parotid swelling.

Ears / Nose
Bilateral ears: normal TMs, no effusion. NGT in left nasal cavity, properly positioned. Nasal mucosa mildly irritated from NGT contact.

5c ORAL CAVITY / OROPHARYNX

ORAL MUCOSA: Mildly dry — dehydration and mouth breathing. No candidiasis (on fluconazole post-antibiotics for pneumonia — recently completed). TONGUE: Midline, intact movement. Right-sided tongue weakness: subtle, tip movement toward right with protrusion (mild). PALATE ELEVATION: Bilateral elevation, left > right — mild right palate elevation lag (UMN pattern). GAG REFLEX: Present bilaterally, reduced on right. TONSILS: Atrophic. POSTERIOR PHARYNX: Mild posterior wall cobblestoning consistent with LPR. SECRETIONS: Mild pooling of secretions in right vallecula noted on inspection — limited anterior view only. RIGHT BUCCAL POUCH: Confirmed — dry cracker placed on right lateral tongue during brief oral test — cracker retained in right cheek x45 seconds before patient cleared it with difficulty.

5d NECK

Neck: supple. No cervical lymphadenopathy. No masses. Thyroid: not enlarged. Trachea: midline. LARYNGEAL ELEVATION: Assessed manually during dry swallow attempt — laryngeal rise felt but reduced compared to expected (estimated 50–60% of normal excursion) — consistent with reduced laryngeal elevation from stroke-related suprahyoid muscle weakness. No crepitus.

5e VOICE / LARYNGEAL FUNCTION

Voice: Dysarthric (right-sided UMN pattern from stroke — slurred, slow, mild labial imprecision). Wet/gurgly quality on sustained 'ahh' — particularly prominent after dry swallow attempts. Prolonged phonation: 'ahh' sustained for 6 seconds (reduced; expected >15 seconds in age-matched females) — consistent with reduced laryngeal closure efficiency. Pitch range: restricted. Cough: voluntary cough weak but present — mildly reduced glottic closure. Maximum phonation time on cough: suggests impaired glottic closure which increases aspiration risk.

5f RESPIRATORY / AIRWAY & NEUROLOGICAL

Respiratory / Airway

Breathing comfortably at rest. SpO2 95% — borderline, has dropped to 93% during pneumonia episodes. No stridor. Mild bibasilar crackles on auscultation (residual from aspiration pneumonia — improving). NGT tube in left naris, secure.

Cranial Nerves / Neurological

CN V: intact. CN VII: right central facial droop (UMN — lower face). CN IX/X: reduced right palate elevation; reduced right gag. CN XII: mild right tongue deviation, intact protrusion. Motor: right hemiparesis — right arm flaccid-to-spastic, right leg mild paresis. Sensation: intact. Cognition: alert, oriented x3, mild expressive word-finding difficulty (mild Broca aphasia component).

PP Procedures Performed

6 SWALLOWING / ENT PROCEDURES THIS VISIT

FLEXIBLE ENDOSCOPIC EVALUATION OF SWALLOWING (FEES) — performed today in-office: Indication: Oropharyngeal dysphagia post-stroke with 2 aspiration pneumonias; assessment of pharyngeal and laryngeal anatomy and function, aspiration risk characterization, and diet level determination. Technique: 4% lidocaine topical nasal spray left naris (around NGT). 3.8mm Olympus ENF flexible laryngoscope passed through RIGHT nasal cavity (NGT in left; scope on right). Assessment performed in sequential food consistency trials: dry swallow, nectar-thick liquid (3 mL ice chip + thickened water), honey-thick liquid (3 mL), and pureed soft (1 tsp applesauce). Color dye added to all test items for visualization. Findings: RESTING LARYNGEAL VIEW: Bilateral vocal cords: right vocal cord slightly reduced in medial excursion during adduction but present — no frank paralysis. Left vocal cord: full mobility. Right arytenoid: sluggish but mobile. Secretions: pooling in bilateral valleculae and right piriform sinus at rest before any bolus — concerning for baseline pharyngeal weakness. Moderate secretion pooling right piriform. DRY SWALLOW: Slow triggering of swallow — approximately 3-second delay from oral phase initiation to laryngeal elevation. Post-swallow: residue in bilateral valleculae. NECTAR-THICK TRIAL (3 mL): Delayed pharyngeal swallow trigger (2 seconds). Laryngeal elevation: reduced. Post-swallow: residue valleculae + right piriform + RIGHT VOCAL CORD — colored residue confirmed on right vocal cord surface (laryngeal penetration, PAS score 3). No penetration-to-aspiration on this trial. HONEY-THICK TRIAL (3 mL): Improved trigger time (1.5 seconds). Post-swallow residue bilateral vallecular + mild right piriform — less than nectar. No penetration observed. PUREED TRIAL (applesauce, 1 tsp): No penetration. Residue in bilateral valleculae — moderate. Cleared with effortful dry swallow. Cough and throat clearing: weak but present voluntarily — protective reflex maintained but reduced efficiency. OVERALL FEES ASSESSMENT: (1) Significant pharyngeal phase dysfunction — delayed trigger, reduced laryngeal elevation, bilateral vallecular residue; (2) Laryngeal penetration on nectar-thick (PAS 3) — at risk for aspiration on this consistency; (3) Honey-thick liquid: safer — no penetration; (4) Pureed: manageable with compensatory strategies; (5) Baseline secretion pooling suggests aspiration of secretions between meals likely contributing to recurrent pneumonia. Patient tolerated procedure well. No adverse events.

L Lab & Dysphagia Diagnostic Results

7 DYSPHAGIA-RELATED DATA

7a SWALLOWING STUDIES

FEES TODAY (see procedures section): Pharyngeal phase dysfunction — delayed trigger, reduced elevation, bilateral vallecular residue, laryngeal penetration on nectar-thick (PAS 3), safer on honey-thick, pureed manageable. Baseline right piriform secretion pooling. Modified Barium Swallow (04/02/2026, during first hospitalization): Oral phase dysfunction from right facial weakness; reduced laryngeal elevation; silent aspiration of thin liquids; trace aspiration of nectar-thick; recommended pureed + nectar-thick. COMPARISON: Penetration now on nectar-thick where prior MBS showed trace aspiration — dysphagia has partially improved (MBS showed silent aspiration thin liquids; FEES today shows penetration not aspiration on nectar-thick) but pharyngeal dysfunction persists. Inpatient SLP assessment (rehab, 04/05–04/22/2026): Reviewed — recommended pureed + nectar-thick, Shaker exercises, Masako and effortful swallow.

7b ENDOSCOPY / GI TESTING

EGD (2022, for LPR): Normal esophagus, no Barrett's, mild gastritis. No prior manometry, pH impedance, or TNE. TRANSNASAL ESOPHAGOSCOPY (TNE): ORDERED TODAY — to evaluate esophageal contribution to dysphagia (globus sensation at upper chest level suggests possible cricopharyngeal bar or Zenker's diverticulum contribution; also to assess LPR severity at the esophageal level). TNE scheduled 05/12/2026.

7c IMAGING & LABORATORY STUDIES

CT CHEST (from second pneumonia admission, 04/25/2026): Right lower lobe consolidation consistent with aspiration pneumonia — improving on antibiotics. No pleural effusion. Brain MRI (03/22/2026, acute stroke): Left MCA territory ischemic infarct — posterior frontal and parietal involvement; cortical and subcortical. Insular cortex involvement — relevant to dysphagia (insular cortex is a key dysphagia-related cortical structure). LABS TODAY: Albumin 2.8 g/dL (low — significant malnutrition); prealbumin 10 mg/dL (low — acute nutritional compromise); CRP 18 mg/L (mildly elevated — residual from pneumonia, improving); CBC WBC 9.2 (normalizing from 14.8 at pneumonia admission); HbA1c 7.8%; TSH 2.6 (normal). Nutritional markers confirm significant protein-calorie malnutrition requiring aggressive nutritional intervention.

7d PATHOLOGY & PRIOR RECORDS

No pathology specimens obtained. Prior records reviewed: Inpatient SLP notes (acute rehab), MBS report (04/02/2026), neurology (Dr. Farouk) notes including stroke workup, and nursing notes from second pneumonia admission. All reviewed and incorporated into assessment.

A Assessment

8 DYSPHAGIA CLINICAL INTERPRETATION

Mrs. Eleanor Sutton is a 76-year-old female with COMPLEX MULTIFACTORIAL OROPHARYNGEAL DYSPHAGIA following left MCA ischemic stroke, characterized by: (1) NEUROGENIC DYSPHAGIA (primary) — post-stroke pharyngeal phase dysfunction: delayed swallow trigger, reduced laryngeal elevation, bilateral vallecular residue, and laryngeal penetration on nectar-thick liquids (PAS 3 on FEES today). The stroke has affected both the cortical swallowing control (insular cortex involvement on MRI) and the corticobulbar projections controlling pharyngeal motor function. (2) BASELINE LARYNGEAL SECRETION POOLING — right piriform sinus secretion accumulation at rest is likely the mechanism driving recurrent aspiration pneumonia even between meals (aspiration of pooled secretions during sleep or reduced arousal states). (3) LARYNGOPHARYNGEAL REFLUX CONTRIBUTING — LPR is poorly controlled on current PPI regimen; LPR causes laryngeal mucosal edema and sensory impairment which compounds neurogenic dysphagia and increases aspiration risk. (4) ORAL PHASE DYSFUNCTION — right buccal pocketing from right facial weakness; right tongue tip weakness; reduced labial seal. (5) NUTRITIONAL COMPROMISE — albumin 2.8, prealbumin 10, 18 lb weight loss in 6 weeks — significant protein-calorie malnutrition requiring aggressive enteral nutritional support. (6) CRICOPHARYNGEAL DYSFUNCTION POSSIBLE — globus at upper chest level; TNE ordered to evaluate. ASPIRATION RISK: HIGH — 2 documented aspiration pneumonias, SpO2 95% baseline, pyriform secretion pooling at rest, PAS 3 on FEES. DIET RECOMMENDATION (updated based on today's FEES): Downgrade to HONEY-THICK liquids (IDDSI Level 3, not Level 2/nectar-thick) — penetration on nectar-thick makes this inadequate. Continue IDDSI Level 4 pureed foods. Strict aspiration precautions. Continue NGT supplemental nutrition. PEG tube discussion warranted.

P Plan

9 DYSPHAGIA MANAGEMENT

9a DIAGNOSTICS

TNE (transnasal esophagoscopy): 05/12/2026 — evaluate cricopharyngeal function, globus etiology, esophageal mucosa, and LPR severity. This will also allow visualization of the esophagus without sedation risk. Repeat MBS: deferred — FEES today provides sufficient acute information; MBS to be repeated in 4–6 weeks to assess progress. pH impedance testing: ordered to quantify LPR frequency and guide medication optimization.

9b DIET, NUTRITION & SWALLOWING PRECAUTIONS

DIET UPDATE: Downgrade from nectar-thick to HONEY-THICK liquids (IDDSI Level 3) — FEES shows penetration on nectar-thick; honey-thick is safer. Continue IDDSI Level 4 pureed foods. All thin liquids strictly prohibited. Pills: continue crushed in applesauce. ASPIRATION PRECAUTIONS: Upright 90° during all oral intake + 30 minutes after. Chin-tuck maneuver reinforced for swallowing. Supervised meals only — no eating alone. Avoid eating when fatigued. Small bites (1/4 teaspoon maximum). NUTRITION: NGT to continue — increase Osmolite 1.5 to achieve goal 1,600 kcal/day. Coordinate with dietitian. PEG TUBE: Formally discussed with patient and daughter today. Given 6-week dysphagia trajectory, 2 aspiration pneumonias, ongoing penetration on FEES, and severe malnutrition, a PEG tube is recommended for reliable long-term enteral nutrition if dysphagia does not resolve significantly in next 4–6 weeks. GI referral placed for PEG tube placement planning — decision to be revisited at TNE visit (05/12). Patient and daughter expressed understanding — they want to attempt further swallowing therapy before committing to PEG but agree to revisit.

9c MEDICATIONS & PROCEDURES

LPR MANAGEMENT ESCALATION: Omeprazole 40 mg BID is insufficient — upgrade to pantoprazole 40 mg BID (superior absorption for some patients) + add alginate barrier therapy (Gaviscon Advance) 10 mL QID after meals and at bedtime (mechanical barrier against LPR). Strict dietary LPR precautions: no coffee, alcohol, chocolate, fatty foods, tomato-based foods within 3 hours of sleep. Elevate head of bed 30–45 degrees. CRICOPHARYNGEAL DYSFUNCTION (if confirmed on TNE): cricopharyngeal botulinum toxin injection or dilation discussion to follow. No medication changes to dysphagia otherwise — no pharmacologic dysphagia therapy indicated at this time. Alendronate: continue to hold (cannot take upright x30 minutes post-dose due to mobility restriction — switch to intravenous zoledronic acid annual infusion; endocrinology referral placed).

9d REFERRALS & PATIENT EDUCATION

1. SPEECH-LANGUAGE PATHOLOGY (outpatient): Referral to Dr. Andrea Wells, MS CCC-SLP — weekly dysphagia therapy sessions. Focus: pharyngeal strengthening (Shaker, Masako, effortful swallow), tongue base retraction, laryngeal elevation exercises, and Mendelsohn maneuver. 2. GI: PEG tube planning referral placed (Dr. Raj Patel, MD — GI). 3. NUTRITION: Dietitian Keisha Brown RD — NGT titration + goal nutrition monitoring. 4. ENDOCRINOLOGY: IV zoledronic acid for osteoporosis (unable to take alendronate). 5. PATIENT/FAMILY EDUCATION: Honey-thick liquid instructions given with visual IDDSI guide. Aspiration precautions review — daughter demonstrated correct feeding positioning and small-bite technique. Family educated on signs of aspiration pneumonia requiring ER (fever, increased cough, respiratory distress, altered mental status). PEG tube discussion documented. Prognosis: explained that post-stroke dysphagia typically continues improving over 3–6 months; degree of recovery depends on stroke location and rehabilitation engagement. Given insular cortex involvement, dysphagia may persist beyond 6 months.

F Follow-Up

10 REASSESSMENT PLAN

Follow-Up Schedule

TNE + LPR results review: 05/12/2026. SLP outpatient first session: 05/09/2026. Dietitian: 05/08/2026. GI (PEG planning): 05/15/2026. ENT dysphagia follow-up with repeat FEES: 06/10/2026 (5 weeks) — to reassess penetration/aspiration status, diet level, and PEG decision. pH impedance results: review at 06/10 visit.

TIME DOCUMENTATION & BILLING

Total Time

55 minutes

E/M Level

99205 — New patient, high complexity

Counseling / Coordination Time

20 minutes

Procedure Code(s)

43197 — FEES (flexible laryngoscopy with swallowing evaluation) — swallowing study

Basis for Billing

Medical Decision Making — High Complexity

Primary ICD-10 Code

J69.0 — Pneumonitis due to inhalation of food and vomit (aspiration pneumonia — recurrent)

Secondary ICD-10 Code(s)

R13.12 — Dysphagia, oropharyngeal phase; I63.30 — Cerebral infarction due to thrombosis, unspecified; K21.0 — GERD with esophagitis (LPR); E46 — Unspecified protein-calorie malnutrition

PHYSICIAN NAME, MD	SPECIALTY	DATE	TIME
Linda A. Park, MD	MD — Otolaryngology / Head & Neck Surgery | Board Certified (ABOto)	05/06/2026, 2:30 PM	