

# WellCare Health Plans, Inc.

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# Clinical Coverage Guideline

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## Chronic Vertigo Treatments

**Guideline Number: H195**

**Original Effective Date: 03/20/2011**

**Revision Date: 07/07/2011**

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

# Clinical Coverage Guideline

## Chronic Vertigo Treatments

Original Effective Date : 03/2011

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### DISCLAIMER

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### APPLICATION STATEMENT

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### CLINICAL COVERAGE GUIDELINE

#### A. The Maneuvers for Benign Paroxysmal Positioning Vertigo (BPPV)

##### 1. Diagnosis

- a. Dix-Hallpike or Head Hanging (see below) maneuver  
is considered medically necessary.

92532\* Positional nystagmus test  
\*(Do not report 92532 with evaluation and management services)

- b. Videonystagmography and Electronystagmography

Electronystagmography (ENG) is considered medically necessary for the evaluation of member's with symptoms of vestibular disorders (780.4 dizziness or vertigo, 781.2 dysequilibrium or imbalance).

Videonystagmography (VNG) is considered a medically necessary alternative to ENG for assessment of vestibular disorders.

**Add CPT Codes**

- c. Dynamic Posturography

Dynamic Posturography is considered experimental and investigational and NOT a covered benefit for the following:

- The diagnosis and staging of members with 386.00 – 386.04 Meniere's disease and other balance disorders; OR,
- The differential diagnosis of 340 multiple sclerosis and 780.4 dysequilibrium; OR,
- All other indications

## 2. Treatment

### a. The Canalith Repositioning Procedure (Epley maneuver)

is considered medically necessary for the treatment of BPPV when the following criteria are met: (See description below). This procedure is successful 50% of the time after **3 or 4 treatments**. 30% of patients have symptoms recur within one year and may need repeat treatment. Note the Semont maneuver is an alternative but is not in favor in the United States and involves rapidly moving from one side lying position to the opposite side lying position and is 90% effective after 4 treatments.

**95992\*\* Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver) per day  
\*\*(Do not report 95992 in conjunction with 92532)**

- Diagnosis of 386.11 BPPV have been confirmed by a positive Hallpike test; **AND**,
- Member had symptoms of BPPV for at least four months

**The use of the above maneuvers are considered experimental and investigational and NOT a covered benefit for the treatment of the following disorders:**

- 191.6 Primary neoplasm or 198.3 metastatic cerebellar neoplasm; **OR**,
- 225.0, 237.5, 239.6 Cerebellopontine angle tumors; **OR**,
- 340 Multiple sclerosis; **OR**,
- 346.00 – 346.93 Vertiginous migraine; **OR**,
- 345.41 Temporal lobe epilepsy; **OR**,
- 430 – 438.9 Cerebrovascular disease; **OR**,
- Any other disorder other than BPPV

**Mastoid oscillation (mastoid vibration) is considered experimental and investigational and NOT a covered benefit for treatment in members treated with canalith repositioning procedure.**

### b. Vestibular Rehabilitation

**Vestibular rehabilitation for chronic vertigo is considered medically necessary when ALL of the following criteria are met:**

- Symptoms have existed for more than six months; **AND**,
- The member has confirmed diagnosis of a vestibular disorder or has undergone ablative vestibular surgery; **AND**,
- The member has failed medical management (e.g., use of vestibular suppressant medications to reduce symptoms)

**NOTE:** Initially, up to 12 visits (generally given 2 times a week for 6 weeks) are considered medically necessary. Up to 12 additional visits are considered medically necessary if medical review shows evidence of clinically significant improvement. If there is no such evidence of improvement after 12 visits, additional visits are considered NOT medically necessary.

### c. Meniett Low-Pressure Pulse Generator

The Meniett low-pressure pulse generator is considered experimental and investigational and NOT a covered benefit for the treatment of 386.00 – 386.04 Meniere's disease.

## **BACKGROUND**

### *Benign Paroxysmal Positioning Vertigo (BPPV)*

Benign paroxysmal positioning vertigo (also known as cupulolithiasis or benign paroxysmal positioning nystagmus) is believed to be a mechanical disorder of the inner ear as a consequence of degenerated material lodging in the posterior canal of the ear. The Hallpike maneuver is a specific clinical balance test that when positive, is diagnostic of BPPV. The classical nystagmus (an involuntary, rapid, rhythmic movement of the eyeball, which may be horizontal, vertical, rotatory, or mixed) occurs when the patient's head is rapidly reclined and turned to the affected side. The Semont maneuver and the Epley maneuver (also known as canalith repositioning procedure) are a series of head manipulations performed by trained physicians in an attempt to move the degenerated material along the posterior canal and out its opening, thus eliminating the symptoms.

There is sufficient evidence that the Hallpike maneuver is effective in diagnosing patients with BPPV. There is also enough scientific data to support the safety and effectiveness of the Semont maneuver and the Epley maneuver for the treatment of patients with this condition. Treatment usually requires a single session. Additional 1 to 2 sessions over a 2-week period may be necessary if the patient's condition does not improve or if the condition recurs after the initial session. Mastoid vibration should not be used in conjunction with the Epley maneuver in patients with perilymphatic fistula or a history of retinal detachment.

The American Academy of Neurology (AAN)'s guideline on therapies for BPPV reported strong evidence supporting the canalith repositioning procedure (CRP) as a safe and effective treatment that should be offered to patients of all ages with posterior semicircular canal BPPV.

### *Vestibular Rehabilitation*

Vestibular rehabilitation (VR) entails the use of specific exercises designed to modify patients' responses to head movement and vestibular stimulation. Vestibular rehabilitation cannot prevent the recurrence of active disease, or relieve symptoms without a vestibular origin, or symptoms that are unaffected by position or movement. Patients may be asked to alter head position as well as gaze direction repeatedly, stand for a specified period of time, and perform a specific number of steps with eyes open and shut. Other rehabilitative exercises emphasize balance retraining. Additionally, patients are asked to identify specific positional changes that cause vertigo; the therapy is then designed to have patients execute that position with varying repetitions. After the initial sessions of instruction, patients can usually carry out vestibular rehabilitation exercises at home. For individuals who are uncomfortable to perform the exercises at home, they can do them in an appropriate facility as outpatients.

Vestibular rehabilitation has been used in the treatment of patients with chronic vertigo as a consequence of vestibular dysfunction. It has been reported that patients with chronic peripheral vestibular disorders improved balance and reduced vertigo after 6 weeks of vestibular rehabilitation. Vestibular rehabilitation has also been demonstrated to be beneficial for patients who have undergone ablative vestibular surgery. Vestibular rehabilitation should be performed by a licensed occupational or physical therapist.

### *Dynamic Posturography*

Dynamic posturography has been used for evaluation of suspected vestibular disorders. This diagnostic test employs a force platform and visual stimuli to measure the contributions to balance of vision, somatosensation, and vestibular sensation. The test measures postural stability (body sway), which is a functional indicator of balance.

Dynamic posturography is an evolving technology and there is insufficient peer reviewed medical literature that addresses its clinical usefulness. CMS's Technology Advisory Committee recently concluded that there is insufficient evidence supporting computerized dynamic posturography's effectiveness for diagnosing balance disorders, or for predicting or influencing the prognosis. Prospective studies are needed to establish the role of dynamic posturography in the diagnosis and treatment of vestibular disorders.

### *Meniett Low-Pressure Pulse Generator*

The Meniett device (Medtronic Xomed, Jacksonville, FL) is a local pulsated pressure treatment used for the management of patients with Meniere's disease. It is a portable pressure-pulse generator designed to restore the balance in the hydrodynamics of the inner ear. After a standard ventilation tube is inserted into the tympanum, pressure pulses generated by the Meniett technology are transmitted into the middle ear. The clinical effect occurs as the pulses reach the inner ear. The typical treatment cycle is completed in 5-minute sessions, performed 3 times a day. After prescription and training by a physician, patients can treat themselves with the device at home. There is some preliminary evidence that the Meniett device may be effective in treating Ménière's disease, but overall there is a paucity of clinical evidence.

### *Electronystagmography*

Electronystagmography (ENG) is used to assess patients with vestibular disorders (e.g., dizziness, vertigo, or balance dysfunction). It provides objective testing of the oculomotor and vestibular systems. In general, the traditional ENG consists of the following 3 components:

- Caloric stimulation of the vestibular system; and
- Oculomotor evaluation (pursuit and saccades); and
- Positioning/positional testing.

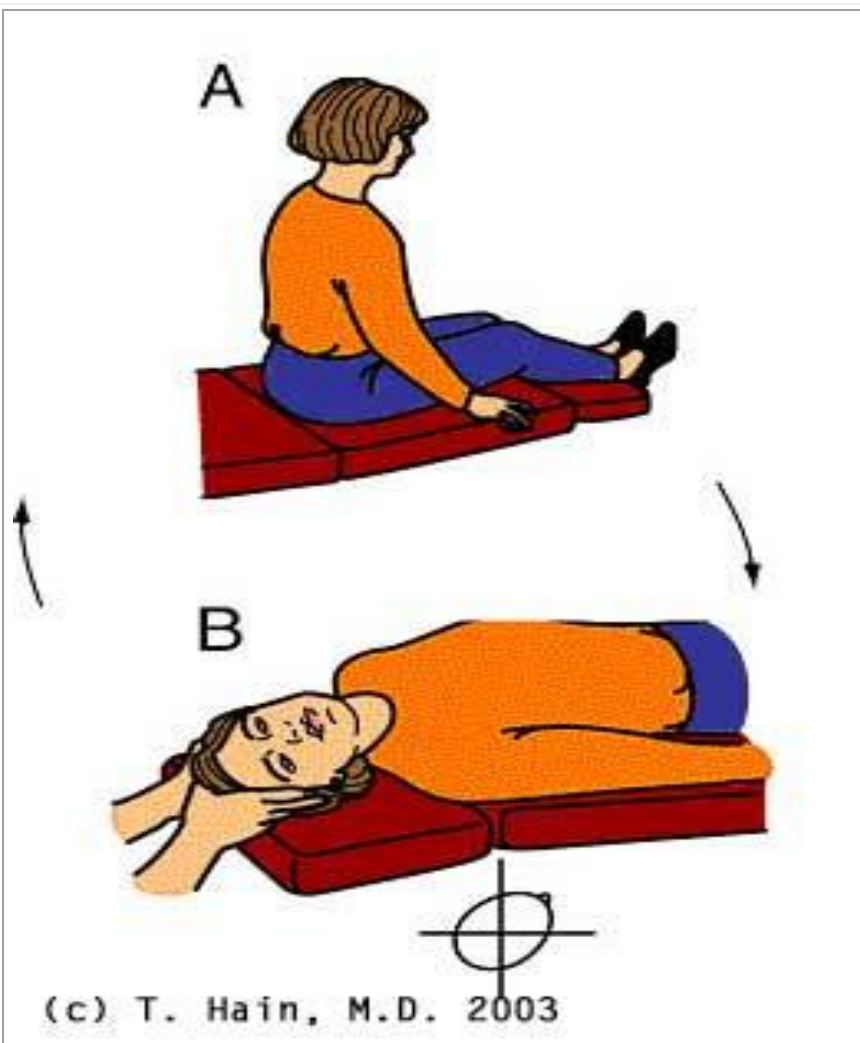
Although ENG can not be used to ascertain the specific site of lesion, the information gathered can be integrated with clinical history, symptoms, and other test results to help in diagnosis. Comparing results obtained from various subtests of an ENG evaluation aids in determining if a disorder is central or peripheral. In peripheral vestibular disorders, the side of lesion can be inferred from the results of caloric stimulation and, to some degree, from positional findings. An ENG evaluation can also be useful in ruling out potential causes of dizziness.

While ENG is the most commonly used clinical test to evaluate vestibular function, normal ENG test results do not necessarily mean that a patient has typical vestibular function. Moreover, ENG abnormalities can be useful in the diagnosis and localization of site of lesion. However, many abnormalities are non-localizing; thus, the clinical history and otological examination of the patient are very important in formulating a diagnosis and treatment plan for a patient who presents with dizziness or vertigo.

Conventional ENG entails the use of electro-oculography to objectively record eye movements. This recording relies on the dipole of the eye (the corneal-retinal potential difference; the cornea is electro-positive relative to the retina). With a fixed recording site, voltage differences can be recorded for eye movements. Small electrodes are placed around the patient's eyes to record the corneal-retinal potential differences. By placing electrodes on both a horizontal and vertical axis around the eyes, tracings are produced for eye movements on both axes.

### **Dix-Hallpike Maneuver:**

The Dix-Hallpike test, also called the "Hallpike" is the definitive diagnostic test for [Benign Paroxysmal Positional Vertigo \(BPPV\)](#).



This figure illustrates the Dix-Hallpike test for BPPV. A patient is moved from a sitting position to a supine position, with the head turned 45 degrees to one side. Once supine, the eyes are typically observed for nystagmus. If nystagmus ensues, the person is brought back to sitting position, and then the other side is tested.

When doing the Dix-Hallpike on a flat table, it is often helpful to place a mat under the person's back, to obtain head extension. One mat-table illustration)

If the person has arthritis in their neck, the maneuver may be modified.

A positive Dix-Hallpike test consists of a burst of nystagmus (jumping of the eyes). In classic posterior canal BPPV, the eyes jump upward as well as twist so that the top part of the eye jumps toward the down side.

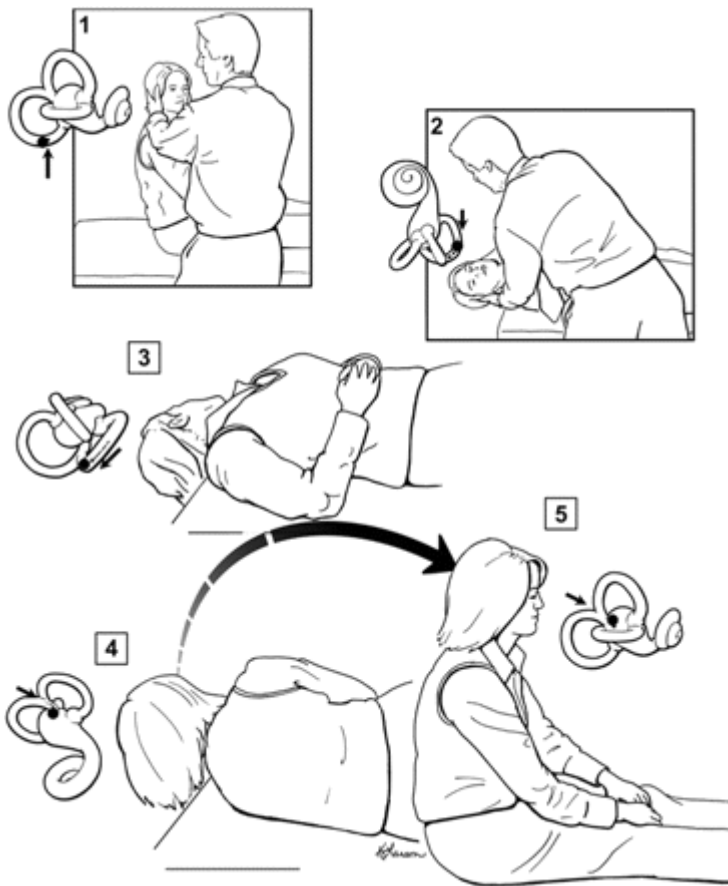
## Canalith Repositioning Procedure

### Background

The canalith repositioning procedure was a remarkable discovery when it was first introduced. The procedure involves laying the patient back onto an examination table into a position that causes movement of the canaliths, which is the trigger of the vertigo symptoms and the nystagmus. (Figure) Moving the patient into this first position is called the "Dix-Hallpike test". The Dix-Hallpike test is necessary to confirm the diagnosis of BPPV and localize the side (left or right) and the site (posterior, anterior, or horizontal semi-circular canal) of the canaliths causing the patient's symptoms. If the patient has a positive Dix-Hallpike test, then the patient is guided through a series of movements (Figure) before being brought back up to the sitting position. The series of positions results in the particles moving around in the canal toward the opening of the canal. When the patient sits up quickly the canaliths fall out of the canal and back into the middle chamber where they do not cause symptoms.

Proper and effective use of the CRP requires clearly identifying the affected side, proper positioning of the patient's head

during the procedure, and waiting the appropriate intervals in-between the steps of the procedure.



**Figure. Canalith repositioning procedure for right-sided benign paroxysmal positional vertigo.**

Steps 1 and 2 are identical to the Dix–Hallpike maneuver. The patient is held in the right head hanging position (Step 2) for 20 to 30 seconds, and then in Step 3 the head is turned 90 degrees toward the unaffected side. Step 3 is held for 20 to 30 seconds before turning the head another 90 degrees (Step 4) so the head is nearly in the face-down position. Step 4 is held for 20 to 30 seconds, and then the patient is brought to the sitting up position. The movement of the canalith material within the labyrinth is depicted with each step, showing how canaliths are moved from the semicircular canal to the vestibule. Although it is advisable for the examiner to guide the patient through these steps, it is the patient's head position that is the key to a successful treatment. (Figure from Fife, et al. *Neurology* 2008;70:2067-74)

## CODING

### CPT® Codes

- 92532\*** Positional nystagmus test  
\*(Do not report 92532 with evaluation and management services)
- 95992\*\*** Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver) per day  
\*\*(Do not report 95992 in conjunction with 92532)

## ICD-9-CM Procedure Code

Not applicable

## HCPCS Level II® Codes

No applicable codes

## Covered ICD-9-CM Diagnosis Codes

**386.11** Benign paroxysmal positional vertigo [BPPV]

\*Current Procedural Terminology (CPT®) ©2011 American Medical Association: Chicago, IL.

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