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Clinical Coverage Guideline

WellCare Prescription Insurance, Inc.



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Chronic Vertigo Treatments

Guideline Number: HS-195

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.

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DISCLAIMER

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APPLICATION STATEMENT

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

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

1. Diagnosis 386.11 BPPV

- 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).

Electronystagmography

92540 Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus with recording, positional nystagmus test, minimum of 4 positions with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording and oscillating tracking test with recording.

92541 Spontaneous nystagmus test including gaze and fixation nystagmus with recording

92542 Positional nystagmus test, minimum of 4 positions with recording

92543 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests with recording)

92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation with recording

92545 Oscillating tracking test with recording

92546 Sinusoidal vertical axis rotational testing

92547 Use of vertical electrodes; List separately in addition to code for primary procedure 92540 - 92546

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

Videonystagmography

92542 Positional nystagmus test, minimum of 4 positions with recording, i.e. video recording

c. Dynamic Posturography CPT 92458

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 CPT Codes 97001, 97002 and 97112

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 DME HCPCS Level II Code E2120

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.

d. Vestibular Rehabilitation CPT Codes 97001, 97002 and 97112

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 **CPT 92458**

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 **HCPCS Level II Code E2120**

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 **CPT 92540 - 92547**

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.

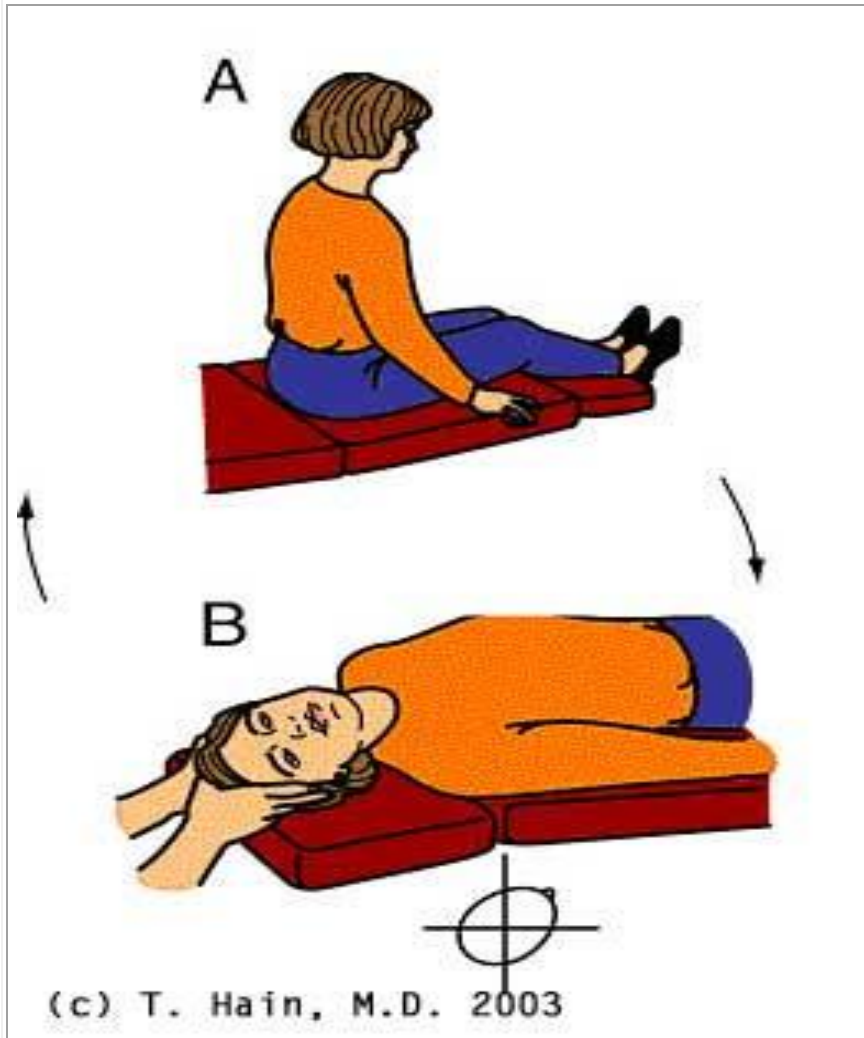
Although ENG can not be used to ascertain the specific site of lesion, the information gathered can be integrated with clinical history, symptoms, and other test results to help in diagnosis. Comparing results obtained from various subtests of an ENG evaluation aids in determining if a disorder is central 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 CPT 92532

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](#) in the supine position, with the head turned 45 degrees backward. Once supine, the eyes are typically observed for nystagmus. If nystagmus ensues, the person is brought back to the sitting position again, and then the other side is tested.

When doing the Dix-Hallpike on a flat table, it is common to place a mat under the person's back, to obtain head extension (see mat-table illustration)

If the person has arthritis in their neck, the maneuver should 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 CPT 95992

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.

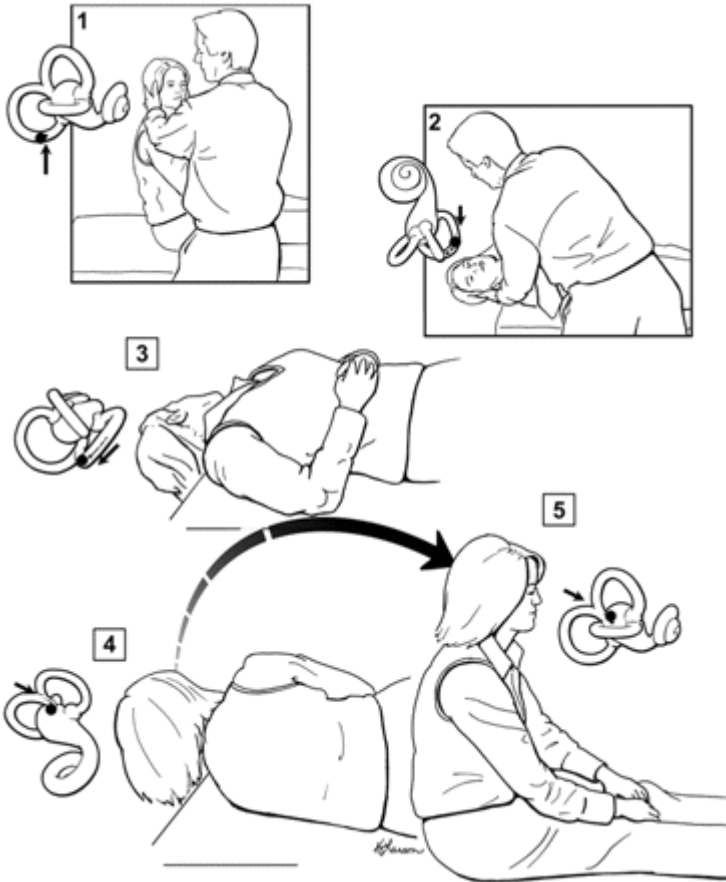


Figure. Canalith repositioning procedure for right-sided benign paroxysmal positional vertigo.

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

ICD-9-CM Diagnosis Code meeting medical necessity for Chronic Vestibular Treatments

386.11 Benign paroxysmal positional vertigo [BPPV]

CPT® Codes

- 92532*** Positional nystagmus test *(Do not report 92532 with evaluation and management services)
95992** Canalith repositioning procedure; Epley or Semont maneuvers; per day.

** (Do not report 95992 in conjunction with 92532)

Electronystagmography

- 92540** Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus with recording, positional nystagmus test, minimum of 4 positions with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording and oscillating tracking test with recording.
92541 Spontaneous nystagmus test including gaze and fixation nystagmus with recording
92542 Positional nystagmus test, minimum of 4 positions with recording;
92543 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests with recording
92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation with recording
92545 Oscillating tracking test with recording
92546 Sinusoidal vertical axis rotational testing
92547 Use of vertical electrodes; List separately in addition to code for primary procedure 92540 - 92546

Vestibular Rehabilitation

- 97001** Physical therapy evaluation
97002 Physical therapy re-evaluation
97112 Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and or/ proprioception for sitting and / or standing activities.

HCPCS Level II® Codes

- S9476+** Vestibular rehabilitation program, nonphysician provider, per diem
+Note: S-Codes are NON COVERED FOR MEDICARE – Refer to HCPCS Level II Temporary National Codes
For Medicare, bill the appropriate CPT code listed above

ICD-9-CM Procedure Code 93.39 Other physical therapy

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