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.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). 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 CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

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 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 pulsed 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 cannot 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.

**POSITION STATEMENT**

**Applicable To:**
- Medicaid
- Medicare

**Exclusions**

The following are considered experimental and investigational and NOT a covered benefit:

- Dynamic Posturography is considered experimental and investigational and NOT a covered benefit for the following:
  a. The diagnosis and staging of members with Meniere’s disease and other balance disorders; OR,
  b. The differential diagnosis of multiple sclerosis and dysequilibrium; OR,
  c. All other indications.

- Meniett Low-Pressure Pulse Generator is considered experimental and investigational and NOT a covered benefit for the treatment of Meniere’s disease.

- The use of the approved maneuvers are considered experimental and investigational and NOT a covered benefit for the treatment of the following disorders:
  a. Primary neoplasm OR
  b. Metastatic cerebellar neoplasm; OR,
  c. Cerebellopontine angle tumors; OR,
  d. Multiple sclerosis; OR,
  e. Vertiginous migraine; OR,
  f. Temporal lobe epilepsy; OR,
  g. Cerebrovascular disease; OR,
  h. 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.
Coverage

The Dix-Hallpike or Head Hanging maneuver is considered medically necessary for any of the following diagnosis:

- Benign paroxysmal positional vertigo [BPPV]; OR,
- Dizziness and Giddiness; OR,
- Abnormality of Gait.

Electronystagmography (ENG) and Videonystagmography (VNG) are considered medically necessary when:

- There is a documented case history of the member's symptoms including severity of symptoms, length of time for which symptoms have been present, exacerbation and relief measures, associated symptoms, general health history and medications used; AND,
- Member has documented orthostatic blood pressure measurements and evaluation for cardiac arrhythmias (ECG or EKG); AND,
- Member has completed a quality of life questionnaire to assess their perceived handicap; AND,
- Member has had a negative Dix-Hallpike test to rule out benign paroxysmal positional vertigo of the posterior or anterior semicircular canals; AND,
- Member has had a documented tympanometry test to rule out impaction of cerumen or tympanic membrane perforation.

Canalith Repositioning Procedure (Epley Maneuver) is considered medically necessary for the treatment of BPPV when the following are met:

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

NOTE: 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. 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.

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,
- Member has confirmed diagnosis of a vestibular disorder or has undergone ablative vestibular surgery; AND,
- 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.

CODING

Covered 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)
92537 Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)
92538 - monothermal (ie, one irrigation in each ear for a total of two irrigations)
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;
92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation with recording

Clinical Coverage Guideline

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
92550 Tympanometry and reflex threshold measurements (This code includes Tympanometry, acoustic reflex testing individual codes (92567-92568)

Vestibular Rehabilitation
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.
97161 Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162 Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163 Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164 Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.

Related HCPCS Level II Code
S9476+ Vestibular rehabilitation program, nonphysician provider, per diem
+Note: S-Codes are NON COVERED FOR MEDICARE – For Medicare, bill the appropriate CPT code

ICD-10-PCS Code – No applicable codes.

Covered ICD-10-CM Diagnosis Codes CPT 92537 – 92547, 92532 and 95992
H81.10 – H81.13 Benign paroxysmal vertigo
H83.90 – H83.93 Unspecified disease of inner ear, unspecified ear - Unspecified disease of inner ear, bilateral
R26.0 Ataxic gait
R26.1 Paralytic gait
R26.81 – R26.89 Other abnormalities of gait and mobility
R26.9 Unspecified abnormalities of gait and mobility
R42 Dizziness and giddiness

Covered codes for Vestibular Rehabilitation
CPT Codes: 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97169, 97170, 97171, 97172

Clinical Coverage Guideline page 5
ICD-10 Codes:
H81.20-H81.23 Vestibular neuritis
H81.90-H81.93 Disorders of vestibular function

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES


MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>1/11/2018</td>
<td>Approved by MPC. No changes.</td>
</tr>
<tr>
<td>2/2/2017</td>
<td>Approved by MPC. Expanded criteria for ENG/VNG procedure.</td>
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<tr>
<td>2/4/2016</td>
<td>Approved by MPC. No changes.</td>
</tr>
<tr>
<td>2/5/2015</td>
<td>Approved by MPC. Restructured Position Statement for clarification; no change to coverage.</td>
</tr>
<tr>
<td>7/10/2014</td>
<td>Approved by MPC. Included criteria for benign paroxysmal positional vertigo and vestibular rehab.</td>
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<tr>
<td>6/6/2013, 6/7/2012</td>
<td>Approved by MPC. No changes.</td>
</tr>
<tr>
<td>12/1/2011</td>
<td>New template design approved by MPC.</td>
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<tr>
<td></td>
<td>Incorporated Canalith Repositioning and CVT the two guidelines into one; added diagnosis code. Also coding information on Electronystagmography &amp; Videonystagmography.</td>
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