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Subject: Vestibular Rehabilitation

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

Position Statement	Billing/Coding	Reimbursement	Program Exceptions	Definitions	Related Guidelines
Other	References	Updates			

DESCRIPTION:

Vestibular rehabilitation therapy (VRT) is a form of physical therapy that uses specialized exercises that result in gaze and gait stabilization. Most VRT exercises involve head movement, and head movements are essential in stimulating and retraining the vestibular system. Vestibular rehabilitation therapy is a modality for treatment of disorders of the vestibular or central balance system.

Evaluation for vestibular rehabilitation may include one or more of the following commonly performed types of vestibular testing:

- Caloric testing
- Electronystagmography (ENG)
- Videonystagmography (VNG)
- Clinical head shaking test
- Rotational/rotary chair testing (computer-driven chair rotations)
- Passive examiner-generated head rotation testing
- Active head rotation (self-generated head turns)
- Hyperventilation induced nystagmus test
- Visual fixation of vestibular nystagmus maneuver
- Dynamic or head shaking acuity testing
- Head impulse or head thrust test
- Video head impulse test (vHIT)
- Optokinetic nystagmus test
- Spontaneous nystagmus test
- Valsalva test for nystagmus

- Vibration induced nystagmus testing (VIN)
- Modified clinical test of sensory interaction on balance (mCTSIB)
- Skull vibration induced nystagmus testing (SVINT)
- Bone conduction vibration
- Computerized dynamic visual acuity (DVA)
- Subjective visual vertical testing
- Saccades (calibration) test
- Saccadic eye movement test
- Vestibular autorotation (VAT)
- Speech-in-noise (SIN) test

Assessment should also include a complete medical history and a detailed history of the balance symptoms including a description of the type of symptoms (e.g., vertigo, imbalance, disequilibrium, pre-syncopal sensations, gait ataxia), frequency and duration of symptoms, specific activities or positions that provoke symptoms, presence of visual disturbances, and the individual's perception of the impact of the symptoms on daily activities.

Summary and Analysis of Evidence: An UpToDate review "Treatment of vertigo" (Furman, Barton, 2025) states that "studies in humans and animal models have shown that clinical recovery after peripheral vestibular injury occurs in advance of improved peripheral vestibular function, suggesting that most of the early recovery and a substantial portion of the total recovery derives from central nervous system compensation. This central compensation appears to be multisensory in its scope and is the primary target of vestibular rehabilitation. There is some evidence that early rehabilitation is more effective than late intervention. Vestibular rehabilitation (physical therapy) promotes recovery in patients with permanent unilateral or bilateral peripheral vestibular hypofunction. It is not known whether vestibular rehabilitation is useful for central vestibular disorders, although preliminary evidence suggests that it might have benefit. Most patients with vertigo prefer to lie with their head still. Vestibular rehabilitation forces them to perform challenging balance exercises with several potential benefits.The brain can readjust or adapt its responses to take into account reduced vestibular input, particularly if one side is still normal. This is optimally accomplished when the brain has experience with vision during head motion, to determine how much error the lesion has introduced. There are other means of reducing spatial uncertainty, even if the vestibular system cannot recover. The cervico-ocular reflex can increase its input, and other eye movements can help stabilize gaze. Alternative spatial cues from vision and proprioception can improve balance and walking. Patients may become physically deconditioned, which exacerbates the inadequacy of their postural reflexes. They may also become psychologically deconditioned, sometimes to the point where a "persistent postural-perceptual dizziness" (previously called phobic postural vertigo or chronic subjective dizziness) becomes the greatest obstacle to their recovery. Fear of falling is particularly problematic in older adults after a vestibular event, and it can limit mobility indefinitely without a rehabilitation program." The review further states, "vestibular exercises have been used for 60 years. However, they have only more recently been studied in randomized, controlled trials. Limitations of these studies include that they are unblinded with short-term follow-up. The evidence of their benefit is most robust for unilateral peripheral vestibular disorders. There is not sufficient evidence to determine whether one form of rehabilitation is more effective than another.

An UpToDate review, "Benign paroxysmal positional vertigo" (Barton, 2025), states that vestibular rehabilitation has a limited role in the treatment of BPPV; the preponderance of evidence suggests that particle repositioning maneuvers are more effective. Two studies have examined the role of the addition of vestibular rehabilitation to particle repositioning maneuvers, suggesting that patients who receive both treatments are less likely to have a recurrence and have better balance at two weeks compared with those who have repositioning maneuvers alone. An impact on longer-term outcomes was not examined." The Vestibular Disorders Association (VeDA, 2021) states, "vestibular/balance rehabilitation therapy works to desensitize or habituate patients to motion stimuli. In 2014, the first small study on the efficacy of

VBRT specifically for PPPD patients was completed. Its results support previous clinical experience and suggested the following: “1) VBRT reduces the severity of vestibular symptoms by 60 % to 80 %, resulting in increased mobility and enhanced daily functioning; and 2) VBRT may be effective in reducing anxiety and depression in patients with PPPD; and 3) patients should continue VBRT for 3 to 6 months to receive maximum benefit from the treatments.”

An UpToDate review “Approach to the patient with dizziness” (Barton, 2025) states, “psychiatric disorders may be the primary cause of nonspecific dizziness in some cases. One-quarter of such individuals had major depression, one-quarter had generalized anxiety or panic disorder, and the remainder had somatization disorder, alcohol dependence, and/or personality disorder in one series. Other series report higher rates of panic disorder. Ill-defined disorders such as fibromyalgia have also been associated with dizziness and vertigo. Patients who have a chief cause of dizziness that is not psychiatric may also have a psychiatric disorder as a contributing factor. Psychotherapy may help manage this type of dizziness. A meta-analysis of three randomized trials that used cognitive behavioral therapy in combination with relaxation techniques or vestibular rehabilitation found that therapy was helpful in managing dizziness in the short term, although not associated anxiety and depression.”

An UpToDate review “Vestibular neuritis and labyrinthitis” (Furman, 2025) states, “vestibular exercises have been shown to be efficacious in improving symptoms and functioning as measured by a variety of symptom- and examination-based scores in patients with unilateral peripheral vestibular injury. In our clinical experience and that of other experts, these measured improvements are clinically meaningful.”

AnUpToDate review “Meniere disease” (Moskowitz, Dinces; 2025) states, “for patients with persistent disequilibrium between vertigo attacks, we suggest referral for vestibular rehabilitation therapy. Vestibular rehabilitation uses exercises to maximize balance and improve central nervous system compensation, both of which are helpful in managing disequilibrium symptoms. Studies evaluating vestibular rehabilitation specifically for patients with MD have had inconsistent results, likely in part due to different patient subsets evaluated and different forms of vestibular rehabilitation employed. In our experience, vestibular rehabilitation helps improve interictal disequilibrium for many patients, with a very low risk of harm. This treatment modality is better studied in the broader group of patients with peripheral vestibular dysfunction from any cause, and has been shown to improve dizziness symptoms in this population.”

POSITION STATEMENT:

Vestibular rehabilitation **meets the definition of medical necessity** for the treatment of chronic vertigo when **ALL** of the following criteria are met:

A. The individual has a diagnosis of a vestibular disorder (eg, Ménière’s disease, vertigo, benign paroxysmal positioning vertigo) or has had ablative vestibular surgery

B. Symptoms of vertigo and imbalance have existed for duration of 8 weeks or more

C. The individual has persistent symptoms despite optimal medical management such as vestibular suppressant medication prescribed to reduce symptoms

BILLING/CODING INFORMATION:

The following codes may be used to describe vestibular rehabilitation:

HCPCS Coding:

S9476	Vestibular rehabilitation program, non-physician provider, per diem

REIMBURSEMENT INFORMATION:

NOTE: Vestibular rehabilitation services are considered part of the contract benefit for rehabilitative services.

LOINC Codes:

The following information may be required documentation to support medical necessity: physician history and physical, physician progress notes, treatment plan, medication history and operative report (if applicable).

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Attending physician visit note	18733-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Treatment plan	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
History of medication use	10160-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Surgical report	28573-4	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage products: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline reviewed date.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

DEFINITIONS:

Saccule: the smaller chamber of the membranous labyrinth of the ear.

Vertigo: the sensation of moving around in space (subjective vertigo) or of having objects move about the person (objective vertigo).

Vestibular: of or relating to the vestibule of the inner ear, the vestibular apparatus, the vestibular nerve, or the labyrinthine sense.

RELATED GUIDELINES:

01-92502-12, Computerized Dynamic Posturography

OTHER:

None applicable.

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 10/22/26.

GUIDELINE UPDATE INFORMATION:

06/15/05	New Medical Coverage Guideline.
06/15/07	Scheduled review; reformatted guideline; updated references.
06/15/09	Scheduled review of guideline. Update position statement and ICD 9 coding section. Remove reference to canalith repositioning guideline.
10/15/10	Revision; related ICD-10 codes added.
06/15/11	Scheduled review; Position Statement unchanged; references updated; formatting changes.
09/15/11	Revision; formatting changes.
02/15/14	Revision; Program Exceptions section updated.
11/01/15	Revision: ICD-9 Codes deleted.
10/01/16	Revision: Billing/Coding Information section updated.
10/15/18	Revision: Updated description, related guidelines, and references. Reformatted guideline.
09/15/20	Scheduled review. Revised description. Maintained position statement and updated references.
06/15/22	Scheduled review. Revised description, maintained position statement, and updated references.
05/22/23	Update to Program Exceptions section.
01/01/24	Position statements maintained.
11/15/24	Scheduled review. Revised description, maintained position statement and updated references.

11/15/25	Scheduled review. Maintained position statement and updated references.
11/15/26	Review; no change to position statement. Updated references.