01-92502-14

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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:

The vestibular system is an important component in balance control. It includes 5 end organs, 3 semicircular canals sensitive to head rotations, and 2 otolith organs (saccule, utricle) that sense gravity and straight-line (forward, backward, left, right, downward or upward) accelerations. Vertigo is the primary symptom of vestibular dysfunction. It can be experienced as illusory movements such as spinning, swaying, or tilting. Vertigo may be associated with a feeling of being pushed or pulled to the ground, blurred vision, nausea and vomiting, or postural and gait instability. Vertigo may arise from damage or dysfunction of the vestibular labyrinth, vestibular nerve, or central vestibular structures in the brainstem. Vertigo may be caused by loose particles (otoconia) from the otolith organs that pass into 1 of the semicircular canals, most frequently the posterior canal. Specific head movements cause the particle to stimulate the canal, causing brief benign paroxysmal positional vertigo.

The central vestibular system is able to compensate for loss of peripheral vestibular function. Thus, the primary therapy for peripheral vestibular dysfunction is exercise-based and includes exercises to promote gaze stability, habituate symptoms, and improve balance and gait. Medications such as vestibular suppressants or antiemetics may be used in the acute stage but are not recommended for chronic use. For those who have recurrent symptoms uncontrolled by other methods, a surgical or ablative approach may be used. The objective of ablation is to stabilize the deficit to allow central compensation.

Evaluation for vestibular rehabilitation may include one or more of the following:

- Caloric vestibular testing [electronystagmography (ENG) or infrared videonystagmography (VNG)]
- Clinical head shaking test
- Rotational 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
- Optokinetic nystagmus test
- Spontaneous nystagmus test
- Valsalva test for nystagmus
- Vibration induced nystagmus testing (VIN)
- Skull vibration induced nystagmus testing (SVINT)
- Bone conduction vibration

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.

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.

DEFINITIONS:

Cupula: the bony apex of the cochlea.

Otoconia: small crystals of calcium carbonate in the saccule and utricle of the ear that under the influence of acceleration in a straight line cause stimulation of the hair cells by their movement relative to the gelatinous supporting substrate containing the embedded cilia of the hair cells – called also *statoconia.*

Proprioceptive: activated by, relating to, or being stimuli arising within the organism.

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

Utricle: the part of the membranous labyrinth of the ear into which the semicircular canals open.

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 & Coverage Committee on 08/27/20.

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.