Subject: Computerized Dynamic Posturography

Policy Number: NMP201

Effective Date*: February 2005

Updated: July 2016

This National Medical Policy is subject to the terms in the IMPORTANT NOTICE at the end of this document

For Medicaid Plans: Please refer to the appropriate State’s Medicaid manual(s), publication(s), citation(s), and documented guidance for coverage criteria and benefit guidelines prior to applying Health Net Medical Policies

The Centers for Medicare & Medicaid Services (CMS)
For Medicare Advantage members please refer to the following for coverage guidelines first:

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<tr>
<th>Use</th>
<th>Source</th>
<th>Reference/Website Link</th>
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<tr>
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<td>National Coverage Determination (NCD)</td>
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<td>National Coverage Manual Citation</td>
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<td>None</td>
<td>Use Health Net Policy</td>
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Instructions
- Medicare NCDs and National Coverage Manuals apply to ALL Medicare members in ALL regions.
- Medicare LCDs and Articles apply to members in specific regions. To access your specific region, select the link provided under “Reference/Website” and follow the search instructions. Enter the topic and your specific state to find the coverage determinations for your region. *Note: Health Net must follow local coverage determinations (LCDs) of Medicare Administration Contractors (MACs) located outside their service area when those MACs have exclusive coverage of an item or service. (CMS Manual Chapter 4 Section 90.2)
• If more than one source is checked, you need to access all sources as, on occasion, an LCD or article contains additional coverage information than contained in the NCD or National Coverage Manual.
• If there is no NCD, National Coverage Manual or region specific LCD/Article, follow the Health Net Hierarchy of Medical Resources for guidance.

Current Policy Statement
Health Net, Inc. considers computerized dynamic posturography / Equitest posturography not medically necessary as a method of assessing balance control because its clinical value has not been established. There is insufficient evidence in the medical literature to determine whether or not dynamic posturography is able to distinguish between peripheral and central vestibular dysfunction and to substantiate the sensitivity and specificity of this test relative to a reliable and valid standard.

Note: The NeuroCom EquiTest is a U.S. Food and Drug Administration (FDA) approved dynamic posturography device.

Codes Related To This Policy
NOTE:
The codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit documents and medical necessity criteria. This list of codes may not be all inclusive.

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures have been replaced by ICD-10 code sets.

ICD-9 Codes (May not be all inclusive)
386.0 – 386.9 Vertiginous syndromes and other disorders of vestibular system
437.9 Cerebral vascular lesion NOS
438.84 Ataxia
438.85 Vertigo
780.4 Dizziness and giddiness
781.3 Lack of coordination

ICD-10 Codes
H81.01-H81.399 Disorders of vestibular function
I67.9 Cerebrovascular disease, unspecified
R26.0 Ataxic gait
R27.0-R27.9 Other lack of coordination
R42 Dizziness and giddiness

CPT Codes
92548 Computerized dynamic posturography

HCPCS Codes
N/A

Scientific Rationale – September 2010
There continues to be a lack of well-designed prospective randomized controlled trials demonstrating the diagnostic utility of computerized dynamic posturography
compared with standard tests. There also lacks peer review data demonstrating any beneficial effects of computerized dynamic posturography evaluation on patient outcomes.

**Scientific Rationale – Update August 2008**
Recently, several local Medicare carriers have issued local coverage determinations that allow for coverage of computerized dynamic posturography when specific criteria as noted above is met.

Peer review published literature regarding computerized dynamic posturography is limited. Borah et al (2007) investigated the changes in postural stability with aging 64 healthy individuals aged eight to seventy years using dynamic posturography. Three tests, namely sensory organization test, limits of stability and rhythmic weight shift which included a total of ten parameters were done. Of these, equilibrium score, strategy score, reaction time, movement velocity and on axis velocity showed statistically significant deterioration with progression of age. Disturbances in postural stability were detected from the fourth decade onwards in the population studied. This instability was not related to any disease process and possibly reflects the process of aging.

In a retrospective review, Gouveris et al (2007) investigated whether computerized dynamic platform posturography (CDPP) findings in 216 patients with vestibular schwannoma (VS) differ with and without asymmetry on caloric and/or rotational ENG studies. Condition-5-score (C5S) and condition-6-score (C6S) of CDPP (Equitest) were compared among patients with normal caloric and rotational studies, patients with asymmetry on caloric studies and normal rotational studies, and patients with asymmetric caloric and rotational studies using the Wilcoxon-Mann-Whitney test. The investigator reported that C5S and C6S of VS patients with normal caloric and rotational studies were significantly higher than in VS patients with either asymmetry on both rotational and caloric test results or normal rotational studies and asymmetry on caloric testing. Neither C5S nor C6S were significantly different between patients with asymmetry on caloric testing and normal rotational studies and patients with asymmetry on both rotational and caloric testing. The investigator concluded that C5S and C6S of CDPP could detect the presence of a functional deficit of the lateral semicircular canal (and the superior vestibular nerve), irrespective of the central vestibular compensatory status, in vestibular schwannoma (VS) patients.

There is a lack of well-designed, controlled trials demonstrating the diagnostic utility of CDP compared with standard tests. In addition, there lacks data demonstrating any consistent, beneficial effect of CDP testing on patient outcomes. Further studies are needed to determine the ultimate role of CDP testing in the management of patients with balance disorders.

**Scientific Rationale**
A vestibular disorder expresses itself by vertigo, or a disturbance of balance, with the inability to maintain balance, to stand upright or to walk with a normal gait. Vertigo is the partial or complete loss of spatial orientation, e.g., the sensation that the world is moving relative to the subject. The neurotologic exam focuses on the vestibular system, but tests for balance and coordination encompass all three of the systems responsible for balance: the vestibular system, vision, and the CNS components of proprioception and cerebellar function. After testing, the physician analyzes the interaction of the three systems. Frequently the ENT physician or
neuro-otologist performs specialized vestibular function tests. Many of these tests are nonspecific and can yield evidence of vestibular lesions, but do not identify specific etiologies. It is rare for one of these tests alone to confirm a specific diagnosis, but when the results of several of these tests are evaluated, along with the history, the physician is often able to determine the cause of the vertigo. There can be a strong correlation between certain test results and diagnoses, however, and two specific tests, the Hallpike maneuver and the pressure or fistula test, are specific and can strongly suggest benign positional vertigo and perilymph fistula respectively.

Computerized dynamic posturography is a quantitative method for assessing balance problems in situations intended to isolate the factors that affect balance in everyday experiences that may be caused by peripheral vestibular dysfunction. In patients with debilitating balance disorder, it must be determined whether the cause of the disability is an organic sensory deficit, a central nervous system (CNS) lesion or a non-organic (that is, possibly psychogenic or just overtly simulated) disorder. The equipment for dynamic posturography consists of a harness to prevent falls and a moveable platform surrounded by a moveable visual screen that is computer-controlled. Both can move separately or simultaneously. By altering the angle of the platform or shifting the visual field the test assesses movement coordination and the sensory organization of visual, somatosensory, and vestibular information relevant to postural control. It attempts to identify vestibular dysfunction, that is, disequilibrium, due to pathology of the labyrinthine sensory organs (e.g. semicircular canals and otoliths) and the oculovestibular and somatosensory vestibular pathways.

Available studies fail to evaluate sensitivity and specificity relative to a reliable and valid reference standard. Most studies, that utilized retrospective clinical samples, did not clearly describe the proxy reference standard criteria for diagnosis and did not use blinded interpretation of tests. Studies, which addressed the health outcome effects of treatment decisions based on dynamic posturography, were not available. Thus, it cannot be determined whether the use of dynamic posturography improves health outcomes.

There is insufficient evidence to determine if dynamic posturography detects vestibular dysfunction, distinguishes between peripheral and central vestibular dysfunctions, or whether treatment decision-making would be improved by its use. Therefore, the clinical usefulness of posturography remains unknown and it cannot be determined whether dynamic posturography is as beneficial as any established alternatives.

### Review History

- **February 2005**  
  Medical Advisory Council

- **July 2006**  
  Policy Update, No change

- **March 2007**  
  Code Update

- **August 2007**  
  Update – no revision

- **August 2008**  
  Added local Medicare coverage criteria. No change for commercial members

- **September 2010**  
  Update – Added patient education websites. Code Updates. No revision to policy statement. Added Medicare Table.

- **July 2011**  
  Update – no revisions

- **July 2012**  
  Update – no revisions

- **July 2013**  

- **July 2014**  

- **July 2015**  
This policy is based on the following evidence-based guidelines:


References - Update July 2016


References - Update July 2015


References - Update July 2014


References - Update July 2013


References – Update July 2012


References – Update July 2011

References – Update September 2010

References – Update August 2008

References

Important Notice

General Purpose.
Health Net's National Medical Policies (the "Policies") are developed to assist Health Net in administering plan benefits and determining whether a particular procedure, drug, service or supply is medically necessary. The Policies are based upon a review of the available clinical information including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the drug or device, evidence-based guidelines of governmental bodies, and evidence-based guidelines and positions of select national health professional organizations. Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract, including medical necessity requirements. Health Net may use the Policies to determine whether under the
facts and circumstances of a particular case, the proposed procedure, drug, service or supply is medically necessary. The conclusion that a procedure, drug, service or supply is medically necessary does not constitute coverage. The member’s contract defines which procedure, drug, service or supply is covered, excluded, limited, or subject to dollar caps. The policy provides for clearly written, reasonable and current criteria that have been approved by Health Net’s National Medical Advisory Council (MAC). The clinical criteria and medical policies provide guidelines for determining the medical necessity criteria for specific procedures, equipment, and services. In order to be eligible, all services must be medically necessary and otherwise defined in the member’s benefits contract as described this “Important Notice” disclaimer. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member’s benefits, nor is it intended to dictate to providers how to practice medicine.

**Policy Effective Date and Defined Terms.**
The date of posting is not the effective date of the Policy. The Policy is effective as of the date determined by Health Net. All policies are subject to applicable legal and regulatory mandates and requirements for prior notification. If there is a discrepancy between the policy effective date and legal mandates and regulatory requirements, the requirements of law and regulation shall govern. * In some states, prior notice or posting on the website is required before a policy is deemed effective. For information regarding the effective dates of Policies, contact your provider representative. The Policies do not include definitions. All terms are defined by Health Net. For information regarding the definitions of terms used in the Policies, contact your provider representative.

**Policy Amendment without Notice.**
Health Net reserves the right to amend the Policies without notice to providers or Members. In some states, prior notice or website posting is required before an amendment is deemed effective.

**No Medical Advice.**
The Policies do not constitute medical advice. Health Net does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

**No Authorization or Guarantee of Coverage.**
The Policies do not constitute authorization or guarantee of coverage of particular procedure, drug, service or supply. Members and providers should refer to the Member contract to determine if exclusions, limitations, and dollar caps apply to a particular procedure, drug, service or supply.

**Policy Limitation: Member’s Contract Controls Coverage Determinations.**
Statutory Notice to Members: The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. The determination of coverage for a particular procedure, drug, service or supply is not based upon the Policies, but rather is subject to the facts of the individual clinical case, terms and conditions of the member’s contract, and requirements of applicable laws and regulations. The contract language contains specific terms and conditions, including pre-existing conditions, limitations, exclusions, benefit maximums, eligibility, and other relevant terms and conditions of coverage. In the event the Member’s contract (also known as the benefit contract, coverage document, or evidence of coverage) conflicts with the Policies, the Member’s contract shall govern. The Policies do not replace or amend the Member’s contract.

**Policy Limitation: Legal and Regulatory Mandates and Requirements**
The determinations of coverage for a particular procedure, drug, service or supply is subject to applicable legal and regulatory mandates and requirements. If there is a discrepancy between the Policies and legal mandates and regulatory requirements, the requirements of law and regulation shall govern.

**Reconstructive Surgery**
CA Health and Safety Code 1367.63 requires health care service plans to cover reconstructive surgery. “Reconstructive surgery” means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

1. To improve function or
2. To create a normal appearance, to the extent possible.

Reconstructive surgery does not mean “cosmetic surgery,” which is surgery performed to alter or reshape normal structures of the body in order to improve appearance.
Requests for reconstructive surgery may be denied, if the proposed procedure offers only a minimal improvement in the appearance of the enrollee, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery.

**Reconstructive Surgery after Mastectomy**

California Health and Safety Code 1367.6 requires treatment for breast cancer to cover prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the co-payment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits. "Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

**Policy Limitations: Medicare and Medicaid**

Policies specifically developed to assist Health Net in administering Medicare or Medicaid plan benefits and determining coverage for a particular procedure, drug, service or supply for Medicare or Medicaid members shall not be construed to apply to any other Health Net plans and members. The Policies shall not be interpreted to limit the benefits afforded Medicare and Medicaid members by law and regulation.