Coding and Reimbursement for Vestibular Testing and Treatment

By: Alan Desmond, 2009

This section reviews the **CPT** codes used for vestibular evaluation. **CPT** stands for **Current Procedural Terminology**. The codes and the specific wording and valuation of each code are developed by the American Medical Association (AMA). Once this process is completed at the AMA, recommendations are forwarded to the Centers for Medicare and Medicaid Services (CMS). CMS accepts approximately 95% of codes and valuations submitted by the AMA.

There is difficulty in writing about coding and reimbursement. Coding is policy, not science. Codes and valuations are developed by discussion and consensus opinion. The goal is to establish clear and unambiguous rules, while the reality is that coding language often fails to consider all possibilities. Policy changes over time, and coding language may be interpreted differently in different parts of the country, and by different parties. There are several regions (with several different administrators) that oversee Medicare benefits. Each regions administrator has some latitude in interpreting and enforcing CMS policy. So, what is correct in Kansas may be incorrect in Virginia. What is correct today may be incorrect tomorrow. Consider this when using any information in this section. This is simply my interpretation of current policy.

There are many nuances to coding and billing. Most private insurance companies follow the lead of Medicare, but you might find that some private insurance companies do not cover codes that are covered by Medicare, and vice versa. We find that many private companies do not reimburse for posturography, while Medicare does. This also differs from state to state.

Technology moves faster than policy. On many occasions there are useful, well accepted, clinically proven advancements in procedures that render the original coding language obsolete. In this situation, the clinician must decide to 1. Continue to perform the procedure as described despite having access to “a better way,” 2. Run the risk of performing and billing for a procedure that may not fit the coding language, which can result in penalties and/or requests for repayment, or 3. Petition the AMA to develop a new code or update the language of the code to address technological advances. Currently all the vestibular codes, as written, were intended to be used with an electrode based system. Infra-red video did not exist when the codes were written. For most of the codes, Medicare has not made a distinction between the two types of recording systems. I discuss below where they have made a distinction. These codes are so old there are no vignettes, which is a detailed description of what the procedure entails.

Okay, now that I have you completely confused I should clarify all of this. Sorry! The fact is that coding is a blurry distant moving target. If you bill too conservatively, you hamper your bottom line. If you bill too aggressively, you open yourself up for recovery and penalties. Nobody said this was going to be easy.

There is often no scientific truth, but rather an interpretation (occasionally self serving) of the coding language. When the definitions of a particular code are vague or outdated, there is much confusion. When a policy is not clear, it opens the door for varied interpretation and
potential abuse. When a code is frequently used incorrectly or is abused, Medicare’s response is often to simply deny payment or to so drastically reduce reimbursement that the overuse will be inconsequential financially. In 2004, the code for vertical electrode recordings (92547) was being abused. An irresponsible equipment distributor was promoting electrode based equipment by pointing out how much money could be made by taking advantage of a billing “loophole” surrounding this particular code. Opportunistic practitioners (some, but not most, were Audiologists) started billing excessive amounts for 92547. Medicare’s response was to reduce reimbursement for 92547 from about $45 in 2004 to about $5 for 2005.

These are the CPT codes for vestibular evaluation:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92541</td>
<td>Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording</td>
</tr>
<tr>
<td>92542</td>
<td>Positional nystagmus test, minimum of 4 positions, with recording</td>
</tr>
<tr>
<td>92543</td>
<td>Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests) with recording</td>
</tr>
<tr>
<td>92544</td>
<td>Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording</td>
</tr>
<tr>
<td>92545</td>
<td>Oscillating tracking test, with recording</td>
</tr>
<tr>
<td>92546</td>
<td>Sinusoidal vertical axis rotational testing</td>
</tr>
<tr>
<td>92547</td>
<td>Use of vertical electrodes (List separately in addition to code for primary procedure</td>
</tr>
<tr>
<td>92548</td>
<td>Computerized dynamic posturography</td>
</tr>
</tbody>
</table>

A couple of comments before we explore each code in detail: Since the majority of vestibular patients are geriatric, we will review each code from the Medicare perspective. These interpretations may not apply to non-Medicare patients. There are codes for spontaneous and gaze nystagmus (92531), positional nystagmus (92432), and caloric irrigation (92533) without recording. They are not reimbursable by Medicare, but are considered part of the Evaluation and Management in an office visit. All the codes in the 9254X series require a hard copy recording. In all regions, a hard paper copy of nystagmus recordings and interpretation would suffice. In some regions, a clearly labeled videotape may be accepted for 92541 and 92542. Most of these codes are to be billed only once per date of service. CPT 92543 and 92547 may be billed more than once per day. Details are discussed below.
92541 – Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording

There has been some recent confusion about 92541. It has appeared in an online course that 92541 could not be reported in conjunction with any other 9254X codes. That information is incorrect. Palmetto GBA (a large Medicare administrator) specifically states it is fine. As of spring, 2009, there is no published Medicare policy limiting the use of 92541 when used the same date of service as other vestibular codes.

92542 - Positional nystagmus test, minimum of four positions, with recording

This code applies to performing static and dynamic positional tests. The typical protocol includes the Dix-Hallpike test to both the right and the left, and static positional tests in supine right, center and left. It is not unusual to do more than the described protocol, or to repeat some or all of the described positional tests. It is not appropriate to bill multiple units of 92542 under any circumstances. If you do not do at least 4 positions (sitting counts as one position), you may not bill this code.

Some clinics do not have ENG/VNG capabilities, but they may have a pair of infra-red goggles. In some states, it is acceptable to maintain clearly labeled videotapes. They may be considered hard copy recordings rendering the positional test billable to Medicare.

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

A typical test battery includes 4 separate irrigations (2 warm, 2 cool) for a total of four. Some administrators allow up to 6 if you do ice water in both ears in addition to 2 cool and 2 warm irrigations. You should bill for the number of irrigation performed. A typical test battery of four irrigations would be billed as CPT 92543 times 4 units.

As recently as 2006, you were technically in violation if you billed Medicare for calorics using an air irrigator. In 2004 the AMA CPT Assistant (a subscription periodical detailing AMA CPT codes) interpreted the word “irrigation” to mean only water could be used. The American Academy of Audiology, with support from ASHA and AAO-HNS, protested and they changed the policy – but you will note a recurring theme where it comes down to the choice of wording. For example, if they had used caloric “stimulation” we would not have had that fight, but it probably would have led to something else unforeseen.

Here is the September, 2006 CPT Assistant excerpt: “It would be appropriate to report code 92543 for caloric vestibular testing using air or water. This information supersedes the previously published AMA comment in the November, 2004 issue.”
92544 – Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording

First, let’s try to break this down. “Bidirectional” obviously means tracking the target in both directions. “Foveal or peripheral stimulation” means that the targets may either move from the periphery towards centered (foveal) vision, or from the fovea (centered vision) towards the periphery. The fovea is the center part of the retina where vision is clearest. There is very little controversy surrounding the utilization of this code. Some clinicians argue that true optokinetic stimulation requires the target to cover at least 80% of the visual field. Standard ENG/VNG systems often use a light bar to create an “optokinetic type nystagmus.” There is currently no AMA standard for stimulus type.

92545 – Oscillating tracking test, with recording

The definition of oscillating is: “To swing back and forth with a steady, uninterrupted rhythm.” Therefore, CPT code 92545 clearly refers to smooth pursuit tracking tests. There has never been a code for saccadic tracking, so saccadic testing is not currently billable to Medicare. When these codes were written, it was not possible to accurately measure saccadic latency and velocity. With the advent of computer assisted analysis, saccadic tracking has become a much more useful test that may merit its own CPT code.

92546 – Sinusoidal vertical axis rotational testing

This code is specifically and solely for rotational chair testing. It has been used extensively for Active Head Rotation (AHR) tests, but Medicare is now clear that 92546 should NOT be used for AHR testing. If you look in the AMA CPT Manual for 2008 and 2009 (but not for 2007), under the description for 92546 you see the following: “CPT Assistant Sep 04:13, Feb 05:13.” This refers you to additional detailed descriptions of this code, therefore, making you responsible for knowing this information. The detailed descriptions below clearly state that 92546 is not to be used for AHR tests (footnote 1).

A brief history of 92546 - The code used for rotary chair (92546 – sinusoidal vertical axis rotation) has been in the AMA Manual since before 1990. I have asked AMA to search for the original vignette describing the test, but they have been unable to produce this. This code was originally used to bill for the torsion swing chair test which has been described as, “relatively low cost”, “test duration of less than one minute”, “problems with reliability and sensitivity” (Jacobson, Newman, Kartush). Until 2002, the reimbursement for this code was approximately $25. Practitioners using more modern rotational chair (RC) systems, often as a result of guidance from equipment manufacturers and distributors, began billing multiple units on the same day to reflect the increased capabilities and time involved in using modern RC systems. Some billed per test frequency (up to 7), some billed per test performed on the RC (typically 4). The result was that practitioners were being reimbursed at a rate of $150 to $300 for a full RC
exam. Since this reimbursement was commensurate with the work and expense of the test, the code has not been considered for redefinition or revaluation since it initially went on the book.

Two things happened around 2002: reimbursement increased to about $78 per unit, and manufacturers and distributors heavily promoted an Active Head Rotation (AHR) test that technically fell under the descriptor for 92546 (sinusoidal vertical axis rotation), although this was never the intended use for this code. Manufacturers guided their customers to perform 3 horizontal sweeps, and 3 vertical sweeps, to reduce artifact and increase test reliability. This was clinical advice, and should not have been confused for billing advice. Some distributors offered billing advice and instructed their customers to bill one unit for each sweep, for a total of six units. In 2001, this resulted in a payment of about $150. After 2002, this same billing pattern resulted in a payment of about $460. This windfall was recognized by some equipment distributors and practitioners, and utilization increased dramatically over the next few years. Balance Clinic Packages were being promoted to physician groups that had not previously shown any interest in vestibular testing (see Box 1).

In Feb 2005:13, Sept 04:13, The AMA CPT Coding Assistant issued a statement that 92546 should not be billed for active head rotation testing, and a computer controlled rotating chair must be used (footnote 1). Despite this, many practitioners continue to use this code for AHR. There is one exception. In Florida, a recent Medicare Local Coverage Determination (LCD) states that 92546 may be used for AHR.

**Box 1 - 92546 billed by specialty group-2007**

<table>
<thead>
<tr>
<th>Specialty Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>12%</td>
</tr>
<tr>
<td>Neurology</td>
<td>8%</td>
</tr>
<tr>
<td>Audiology</td>
<td>7.5%</td>
</tr>
<tr>
<td>IDTF (Independent Diagnostic Test Facility)</td>
<td>11%</td>
</tr>
<tr>
<td>Primary care</td>
<td>45%</td>
</tr>
</tbody>
</table>

The result of a poorly defined code descriptor, inconsistent interpretation of the code, and incorrect guidance from equipment distributors is rampant abuse and over-utilization of this code (see Box 2). As is typical, Medicare’s response was to limit the number of units billed to one a day (NCCI edit, July 2007).

**Box 2 - Utilization data for CPT 92546 –tests billed per year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>28,590</td>
</tr>
<tr>
<td>2007</td>
<td>185,814</td>
</tr>
</tbody>
</table>
This leaves us with the current situation: Per Medicare data, modern rotational chair systems cost on average $90,000.00, a RC evaluation takes about 55 minutes, the results must be placed in context with the patient’s history (which takes time and expertise), and is currently reimbursed at approx $78.

Recent studies (Arriaga, Chen, 2004, and Shepard, Telian, 1996) indicate that as many as 50% of patients with diagnosable, treatable vestibular disorders will be missed if RC is not available to them. These patients with undiagnosed vestibular disorders will be subjected to prolonged symptoms and disability, and numerous expensive and fruitless medical examinations.


**Question:** Would it be appropriate to report code 92546, Sinusoidal Vertical Axis Rotational testing, in the absence of a rotational chair if diagnostic results are achieved through a different means (eg, head shake)?

**AMA Comment:** From a CPT coding perspective, code 92546, Sinusoidal vertical axis rotational testing, is intended to describe a very specific procedure to evaluate nystagmus. The patient is seated in a computer-controlled chair with the head bent forward 30 degrees. Electronystagmography electrodes are placed to measure nystagmus while the chair is rotated, under computer control, only the horizontal canal is stimulated. A recording is made and studied to determine an abnormal labyrinthine response on one side or the other. While it is true that only the horizontal canal is being tested, the patient’s body is in the vertical axis position.

Code 92546 is a very different procedure from the head shake test whereby the individual wears webbing like straps on the head with a means to record horizontal nystagmus and an accelerometer to measure velocity and angle. The individual moves the head back and forth, usually in time to a metronome device. It does not give more extensive results than rotational testing; it is simply a different way to measure horizontal nystagmus. Code 92546 is not appropriate to report as a procedure code for the head shake test. It is a distinct procedure with different equipment, protocols, and practice expenses.

**92457 – Use of vertical electrodes (List separately in addition to code for primary procedure)**

This code has been all over the place in the past few years. 92547 is an **add-on code**, meaning it can't be billed independently, but must be attached to one of the other vestibular codes. For example, if you did the spontaneous nystagmus test (92541), **AND** you used electrodes to record the eye movement, you would bill 92541, plus one unit of 92547. You can add one unit of 92547 to each test performed that used electrodes for recording eye movement. Since a typical test battery includes one unit of 92541, 92542, 92544, 92545, and four units of 92543, you would bill 92547 time 8 units.
When you look at the AMA CPT manual for 2008 and 2009, you will see the following listed under each of the 9254X codes listed: CPT Assistant Feb 05:13. This comment guides the reader to an excerpt from the CPT Coding Assistant which reads:

**Question:** “How often is it appropriate to report add-on code 92547, Use of vertical electrodes (list separately in addition to code for primary procedure), when more than one vestibular function test (92541-92546) is performed on the same date of service? Also, is it appropriate to report once per date of service or once for each vestibular test performed?

**AMA Comment:** From a CPT coding perspective, add-on code 92547 should be reported once per date of service, even when several electrodes are placed, and/or when used with multiple other vestibular function tests (i.e, 92541-92546).

For 2005, however, this service has been valued by Medicare and other payors on a per test basis. Therefore, given the definition of the service used in valuing this service for 2005, it would be appropriate to report code 92547 in addition to the code(s) for the primary procedure(s) for each vestibular tests performed.”

There is no current CMS policy regarding the use of this code when performing VNG, and all other codes in the 9254X series are billable when using ENG (electrode based) or VNG (video based) recordings. Some regional administrators have stated specifically that it is **NOT** appropriate to bill 92547 when using VNG recordings. There is sufficient data to support the claim that VNG recordings are superior in many ways to ENG recordings. Disallowing the use of this code when vertical data is recorded by video penalizes practitioners for upgrading their equipment.

**A brief history of 92547** -In 2003, you got more for applying 2 electrodes than you did for the entire rest of the ENG battery. Consider that at 8 units of 92547 (at approximately $45 per unit) you could bill an additional $360 per test battery if you used ENG (as opposed to VNG) recordings. Of course, this triggered much abuse, and CMS reaction was to reduce it so much there was no longer a financial incentive to abuse it. In 2005, Medicare recognized the potential for, and occurrences of, fraud. Since the process of revaluing a code takes time, Medicare’s response was to limit the use of 92547 to just one unit per day. After the code was revalued down to about 5 dollars, 92547 was again allowed to be billed in multiple units along with other electrode based vestibular tests.

Again this problem arose as a result of a poor choice of wording. We can’t know the intent, but I suspect the increased reimbursement was more about collecting and analyzing vertical data, as opposed to the cost of 2 electrodes. If they simply changed the wording to “vertical recording” we wouldn’t be having this discussion. At the time the code was written, electrodes were the only way to gather the data.
92548 – Computerized Dynamic Posturography (CDP)

In the AMA code descriptor there is no detailed description of how this procedure is performed, or what equipment is required. All we have to go on is what you see above: Computerized-Dynamic-Posturography. First, let’s get out the dictionary (Merriam-Websters) and see exactly what each of these words means:

**Computerized** – “to carry out, control, or produce by means of a computer”

**Dynamic** – “Relating to energy or physical force in motion: opposed to static.”

**Posturography** – There is no entry in Merriam-Websters for posturography, so I will use the entry from Wikipedia (proceed with caution). “Posturography is a general term that covers all the techniques used to quantify postural control in upright stance in either static or dynamic conditions.”

It seems clear that in order to qualify for this code, you must perform some technique to assess postural control (there are many), and it must be assisted by a computer (most commercially available posturography units are computer assisted). The defining term then is the word dynamic, which in this context I interpret as “not static.” It appears that a system in which the platform can be moved through computer control would qualify under this description.

One of the larger Medicare regional administrators has interpreted CDP as “… consists of a movable platform surrounded by a movable visual screen that is computer controlled. Both can move separately or simultaneously.”

California (current Medicare administrator is Palmetto GBA) has issued very specific guidelines for the use of 92547. “Computerized dynamic posturography (CDP) is a test of the vestibulospinal system and assesses an individual’s ability to maintain standing balance under a variety of sensory conditions. During this test, the individual stands on two force plates which measure the individual’s postural sway. The dynamic posturography test actually consists of several different subsets of conditions that quantify the patient’s ability to use visual, somatosensory and vestibular cues to maintain standing balance. The motor coordination subtests measure the automatic postural reactions to sudden translational or pitch movements of the support surface. The third subset, the Electromyography (EMG) test, measures the integrity of peripheral and central pathways for motor innervation of the lower limbs as reflected by the onset of motor responses to rotational movements of the support surface. Responses are measured by surface EMG, and related to normal values by age. While the posturography test is a non-localizing test, patterns of performance on the various subtests are helpful in diagnosis of the etiology of vestibular dysfunction. Abnormal findings in the motor control tests or EMG test are indicative of central rather than peripheral vestibular problems. This test is not a simple balance test. “

This is essentially a description of the Neurocom Equitest. Their description is so detailed that only the Neurocom top of the line platforms would qualify. Medicare is not supposed to develop a code for a proprietary procedure, and practitioners in California could petition for a change in language.
92585- Auditory evoked potentials or auditory evoked response audiometry and/or testing of the central nervous system –comprehensive

This code is intended for the performance of a comprehensive ABR (Auditory Brainstem Response) or, as neurology refers to the same test- BAER (Brainstem Auditory Evoked Response). It can also be used for VEMP testing if the stimulus is sound, as VEMP’s are an evoked response to auditory stimulation of the saccule. Since this is also a code that can only be reported once per day, you could not bill for an ABR test and a VEMP performed on the same day.

Treatment

95992 –Canalith Repositioning Procedure (CRP) –This is a new code for 2009, and allows physicians, limited license practitioners and physical therapists to bill for performing canalith repositioning (aka: The Epley Manuever). This code is considered a treatment code, and is therefore not billable to Medicare by an independent practicing audiologist. It can be billed if the audiologist is performing the service “incident to” a supervising physician. It does not require a hard copy recording, so it is not necessary to have ENG/VNG equipment to bill for the procedure (which is the case for positional testing).

As of January, 2009, Medicare has decided that Canalith Repositioning is part of a physician’s evaluation and management (E&M) service. Despite the fact that a code has been developed and valued, Medicare’s current position is that they will not pay for that procedure if performed on the same day as a physician visit. This issue should be revisited as this may be a temporary situation.