



Position Statement on the Audiologist's Role in the Diagnosis and Treatment of Vestibular Disorders

Introduction

It is estimated that at least half of the people living in the United States will be affected by vestibular, or balance, problems sometime during their lives. Vestibular problems may affect individuals throughout the life cycle and may occur in infants as well as elderly individuals. Vestibular disorders may be due to syndromes, disease, toxins, or trauma. They may occur suddenly or develop slowly. Disorders of the vestibular system and its interconnections with the brain may cause a variety of serious problems, including falls, imbalance, dizziness, spatial disorientation, and blurring of vision. Vestibular problems can be acute/chronic and debilitating. The National Institutes of Health National Institute on Deafness and Other Communication Disorders has deemed vestibular disorders a major public health-care concern. The Human Genome Project has identified over 500 nDNA syndromes that affect the audiovestibular system. In the elderly person, balance-related falls are associated with significant morbidity, mortality, and expense to the health-care system.

Scope of Practice

According to the American Academy of Audiology (hereafter, Academy) [Scope of Practice](#), "An audiologist is a person who, by virtue of academic degree, clinical training, and license to practice and/or professional credential, is uniquely qualified to provide a comprehensive array of professional services related to the prevention of hearing loss and the audiologic identification, assessment, diagnosis, and treatment of persons with impairment of auditory and vestibular function, and to the prevention of impairments associated with them" (2004, p. 44).

Education and Training

Audiologists should complete coursework and clinical training in their graduate programs sufficient to allow them to perform and interpret diagnostic vestibular function tests and participate in the treatment of patients. Coursework and clinical training should include:

- Anatomy and physiology of the peripheral and central vestibular systems
- Medical disorders
- Pharmacology
- Patient case history and interview technique
- Clinical and electrophysiological test protocols



- Test interpretation
- Biomechanical aspects of equilibrium
- Vestibular rehabilitation theory, and therapy and treatment protocols
- Clinical rotation with audiologists specializing in vestibular assessment and treatment. If available, rotations with otolaryngology, neurology, and physical therapy.

As education and training may vary, audiologists who intend to practice vestibular diagnostics and treatment must ensure that they have acquired the knowledge and skills necessary to do so. This may require additional postgraduate education and clinical training.

Practitioners are bound by the Academy Code of Ethics Principle 2, “Members shall maintain high standards of professional competence in rendering services, providing only those services for which they are qualified by education and experience.” Therefore, practitioners should engage only in those aspects of the profession that are within their scope of competence, considering their level of education, training, and experience.

As new technologies are unveiled and best clinical practices emerge, audiologists should ensure that their knowledge and skills are kept current. Principal 2, Rule 2f of the Academy Code of Ethics states, “Individuals shall maintain professional competence, including participation in continuing education.”

Patient Care and Safety

Patients with vestibular and balance disorders may have medical conditions or motion sensitivity that cause them to have adverse reactions to diagnostic or treatment procedures. The Academy Code of Ethics Principle 2, Rule 2b states, “Individuals shall exercise all reasonable precautions to avoid injury to persons in the delivery of services.”

In order to enhance patient outcomes by identifying and addressing safety issues, audiologists are encouraged to develop strategies for unanticipated outcomes with their patients. Communicating risks before and after evaluation and treatment procedures can minimize aggravation for both patients and clinicians.

Code of Ethics Principle 5, Rule 5a states, “Individuals shall provide persons served with the information a reasonable person would want to know about the nature and possible effects of services rendered...” Practitioners who conduct or supervise these procedures should have a written plan and specific protocols to alert medical personnel for assistance to ensure patient comfort and safety should the need arise.

Some procedures or patient adverse reactions may introduce the possibility of practitioner exposure to bodily fluids. It is recommended that the practitioner follow the Guidelines for Infection Control in



Health Care Personnel (1998), recommended by the Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services, and the Academy Infection Control Guidelines (2003).

Suggested Evaluation Guidelines

Assessment

Patients who are seen for vestibular evaluation often present with complicated medical and case histories as well as a complex description of their symptoms. Prior to undertaking the evaluation, it is important for audiologists to obtain a comprehensive medical and family history as well as a list of all medications the patient is taking that could influence test results. Case history should include, but not be limited to, nature and onset of symptoms, duration and frequency of episodes or symptoms, and associated symptoms (e.g., visual changes) provoking or exacerbating conditions.

According to the Academy Scope of Practice, “Assessment of the vestibular system includes administration and interpretation of behavioral and electrophysiological tests of equilibrium” (2004, p. 45). Evaluations may incorporate clinical and electrophysiological tests of vestibular and extr vestibular (vision and somatosensory) systems. Tests may include but are not limited to:

- Videoculography (VOG)
- Electronystagmography (ENG)
- Videonystagmography (VNG)
- Tests of dynamic visual acuity
- Tests of active and passive rotation
- Tests of postural stability
- Vestibular Evoked Myogenic Potentials (VEMP)

Audiologic test procedures are customarily included as part of comprehensive vestibular assessment.

Treatment

The Academy Scope of Practice explains that “Audiologists also are involved in the treatment of persons with vestibular disorders. They participate as full members of the balance treatment teams to recommend and carry out treatment and rehabilitation of impairments of vestibular function” (2004, p. 45).

Vestibular rehabilitation therapy is a nonmedical treatment process for patients with vestibular deficits and disorders. The treatment, which has become a standard of care, uses specific exercises to reduce vertigo and to improve gaze and postural stability in individuals with vestibular disorders by facilitating



central neural compensation. Canalith Repositioning and Liberatory maneuvers are treatments for the most common form of positional vertigo, Benign Paroxysmal Positioning Vertigo (BPPV). These procedures are designed to correct biomechanical problems caused by displaced otoconia. The maneuvers are designed to move the otoliths from the affected semicircular canal and back into the utricle where they can be absorbed.

Vestibular Treatment and Therapy protocols may include, but not be limited to:

- Canalith Repositioning and Liberatory maneuvers for the treatment of Benign Paroxysmal Positioning Vertigo (BPPV)
- Adaptation, habituation, and substitution protocols
- Gaze stabilization exercises to strengthen and set gain of the vestibulo-ocular reflex (VOR)
- Static and dynamic balance activities

The assessment of treatment outcomes is considered to be an essential part of the clinical practice. It is from assessment of outcomes that we are able to demonstrate efficacy of our treatment efforts. The assessment of treatment outcomes begins prior to management of dizziness and unsteadiness and represents a baseline measurement. These measures are then repeated post-intervention. Outcome measures may be objective and/or subjective. This may include, but not be limited to evaluation of nystagmus, vestibulo-ocular reflex (VOR), static and dynamic postural stability, dynamic visual acuity, patient ratings, and participation restriction/activity limitation questionnaires.

An interdisciplinary approach to the management of dizzy and unsteady patients may include involvement of primary care and medical subspecialties as well as allied health disciplines including physical and occupational therapy for patients with medical, biomechanical, neuromuscular, and orthopedic comorbidities. Prior to patients undergoing management by the audiologist, any complicating or medical contraindications should be considered and cleared by the appropriate medical disciplines.

Professional Referrals and Consultations

Audiologists should recognize that patients might present with physical impairment or medical and psychological conditions that may not contribute to their symptoms. Practitioners are encouraged to have available a network of referral and consulting specialists for patients whose problems are not vestibular and who require additional medical, psychological, or therapeutic expertise. Patients presenting with dizziness, vertigo, or imbalance may have serious medical or even life-threatening conditions. It is incumbent upon the practitioner to be able to recognize the need for appropriate referral.



CPT Coding and Billing Considerations

Vestibular function test codes are described in the 2004 AMA Current Procedural Terminology (CPT) codebook (p. 276). They include codes 92541–92584. These codes do not encompass all the tests and procedures that may be used in the clinical and electrophysiological examination of the vestibular patient. The rapidly changing nature of the specialty does not always allow for the introduction of new CPT codes as quickly as tests are developed. In other cases, there may be clinical evaluation techniques that do have a specific CPT code.

The federal Medicare program and the dozens of Medicare payer intermediaries throughout the country may vary in their interpretation of requirements to pay for certain procedures. For example, although 92584, the CPT code for Computerized Dynamic Posturography is not mandated by CMS to be paid for, many but not all regional or state Medicare intermediaries will reimburse for the procedure. The existence of the CPT code alone does not, therefore, mean that the intermediary will reimburse for this code. Recently, CMS has confirmed that a written referral is not required. A verbal order will suffice, if the referral is documented in the patient chart/record by both the treating physician and the audiologist. A written referral in the chart, however, may minimize any later discrepancies and may be preferable. Non-Medicare third party payers often act independent of Medicare guidelines. This may result in increased or decreased services by code, number of units and reimbursement amount to audiologists. Due to this disparity among Medicare and non-Medicare payers and state and regional differences, it is recommended that audiologists and their staff attend or participate in billing workshops offered by their respective Medicare intermediary.

Presently, no CPT codes exist for vestibular rehabilitation therapy (VRT). Historically, therapists have used a group of physical medicine codes, (i.e., neuromuscular re-education) that best approximate the nature of the functional treatment. The present interpretation by CMS of the Medicare law does not provide for reimbursement for treatment by audiologists. This category is also outside of the family of CPT codes, for which audiologists are reimbursed. There are numerous managed care organizations (MCOs) that pay audiologists for VRT using the same physical medicine codes. Audiologists are encouraged to work with their managed care network contracts to include all the services and codes that they will be providing to that MCO and its members.

Reimbursement issues affecting nonpayment for vestibular treatment performed by audiologists do not reflect a restricted scope of practice for audiologists but rather a lag in current reimbursement policies by specific insurers. The development and inclusion of vestibular treatment, therapy, or rehabilitation CPT codes, in the future, will hopefully eliminate the present disparity in reimbursement by third-party payers.



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