

Vestibular Rehabilitation SIG

Spring 2009

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Vestibular Rehabilitation SIG Officers:

Chair:

Susan L. Whitney,
PhD, PT, NCS, ATC, FAPTA
whitney@pitt.edu

Vice Chair:

Julie Tilson, PT, DPT, NCS
jtilson@earthlink.net

Secretary:

Michelle Lea Gutierrez, PT
mlgutierrez@zianet.com

Nominating Committee:

Debbie Struiksma, PT, NCS
DStruiksma77@aol.com

Patricia A. Farr Winkler,
PT, D.Sc., NCS
pwinkler@regis.edu

Kenda S Fuller, PT, NCS
kendafuller@hotmail.com

Newsletter Editors:

Sharan Zirges, PT, CWS
SZirges@odu.edu

Elizabeth Grace, PT, NCS
elizabeth.grace@uphs.upenn.edu

SIG Practice Liaison:

Col. Kim Gottshall, PT, Ph.D
kim.gottshall@med.navy.mil

Web Master:

Laura Morris, PT, NCS
ptforbalance@gmail.com

Message from the Chair

**By Susan L. Whitney,
PhD, PT, NCS, ATC, FAPTA
VR SIG Chair**

What an amazing CSM! We had almost 200 people at our Vestibular SIG meeting and probably had the worst time slot on the program! Everyone has to take turns being the last on the program and this year it was the Vestibular SIG's turn. Thanks go to Dr. Susan Herdman for her outstanding talk related to differential diagnosis. Her eye videos and information were invaluable and her drawing power made the difference in the attendance.

During the SIG meeting, we recognized Dr. Denise Gobert for her 6 years of service to the section and raffled off 12 items. We are already planning to get many more items for next year for the raffle including books, DVDs, CDs, etc and will let you know before CSM in San Diego why you should come to our meeting. We had a lot of fun and had over 85 people express interest in building the SIG. The room was filled with energy about moving our special interest of practice forward.

Helene Ferone took questions at the end of the meeting related to the CPT coding issue for BPPV. She answered our questions at the end for programming for almost 45 minutes. CMS has resolved the issue and CMS will pay for the canalith repositioning maneuver (see the article by Kim Gottshall, our practice committee chair). More than Section members charge for the canalith repositioning maneuver so it is important to get our message out to all APTA members.

Julie Tilson, our SIG Vice Chair, did a superb job obtaining outstanding speakers for CSM. She organized our Vestibular SIG programming and had significant input into the Neurology Section programming. The vestibular topics were well attended and all were well done (evidence based with outstanding speakers).

We have some new initiatives related to the SIG. We now have 18 drafts of our new patient data sheets. Our writing task force group has about 25 other topic areas that have been assigned.

When these are completed, they can be used to enhance your practice. Providing consistent information to patients should assist you and the consumer. Our task force team agrees with me that knowledge is power and we are working to empower our patients. Our hope is that you will soon be able to download and print the sheets in order to provide them to your patients. Our team is hoping that this will help to improve your practice. Stay tuned for further progress of this project.

The Vestibular SIG will be the first to try the new bulletin board format. If you are interested, please join in to participate. More information will be forthcoming related to this initiative. We will try the bulletin board for several months to see if it catches on with the membership.

The Neurology Section is being very supportive of our SIG's efforts. Your SIG officers attended several meetings at CSM with the Neurology Section Board of Directors, other SIG offers, plus had our own SIG meeting and a meeting of the patient education task force. We are also working hard to plan for additional tools that can enhance your practice. I will be choosing a new taskforce leader to roll out the fact sheets for physicians and we will be calling on people who volunteered at CSM to see if any are interested in participating.

We are also discussing ways to help physicians and the external community better recognize expertise in the area of vestibular rehabilitation. The Executive Board will be discussing this over the next few months and will try to have a report to all of you during CSM 2010 in San Diego.

We guarantee that we will have more prizes for the CSM business meeting and will try to incentivize you to join the SIG. It is just a few clicks on the Neuro web site. The procedure to sign up for a SIG on line is to visit www.neuropt.org.

Stay tuned to updates on our web page at www.neuropt.org. You have a very talented team working hard to help you to improve practice. Let us know about any concerns that you have and we will try to work to address them.

NEWS ALERT!!

Coding for Canalith Repositioning Procedure Update

Col. Kim Gottshall, PT, Ph.D
VR SIG Practice Liaison

Physical therapists treating vestibular patients for BPPV should be aware of the following ruling regarding the use of CPT code 95992.

In the final physician fee schedule rule, CMS assigned a "bundled" status to CPT code 95992 canalith repositioning maneuver. This means that CPT code 95992 will not be separately paid under Medicare to any provider. APTA staff, along with physical therapist members with expertise in vestibular rehabilitation, met with CMS officials in December to urge them to reverse the decision to assign this CPT code a "bundled" status.

CMS has stated that physical therapists should continue to bill CPT code 97112, Neuromuscular Re-education, for Canalith Repositioning Procedure. This recommendation to use 97112 for billing for the Canalith Repositioning Procedure is appropriate for Medicare patients, in addition to all other insurances.



Specifically the notification regarding the 95992 CPT code read as follows:

Notification of Claims Hold for Canalith Repositioning Procedure (CPT 95992)

Effective immediately, the Centers for Medicare and Medicaid Services (CMS) has instructed all contractors to hold claims that contain CPT 95992 pending the successful implementation of system program changes. The system change is scheduled for March 2, 2009.

Although CPT 95992 is a bundled service under the Medicare Physician Fee Schedule and no separate payment is issued for this code, other CPT codes included on the claim could be reimbursed. Therefore, to mitigate any financial impact for the payable services on the claim, providers should remove CPT 95992 prior to the submission of the claim. Once the system change is implemented, providers may then choose to submit CPT 95992 for a denial.

Reference: JSM09132

01/29/09

Please frequent our Vestibular SIG website for breaking news. We are working to keep you informed with the most recent information for best practice in the world of vestibular physical therapy.

Epley Omniax Presentation during CSM

By Susan L. Whitney, PhD, PT, NCS, ATC, FAPTA
VR SIG Chair

Dr. John Epley, the developer of the Epley maneuver, was in Las Vegas during the Combined Sections Meeting in Las Vegas. He had been invited by Brian Werner, owner of Werner Institute of Balance and Dizziness, Inc. to speak and demonstrate his new Omniax device by Vesticon that is used to treat persons with BPPV. Brian recently purchased the device, which has the ability to reposition in any plane. While a patient is in the device, the clinician can constantly monitor eye position and nystagmus via infrared goggles. The device looks like a flight simulator that one typically sees in science centers or at a space camp (see picture). Several physical therapists had an opportunity to test the device and experience what a patient would feel during the repositioning. The device is commercially available. Dr. Epley also provided a free educational seminar and had his picture taken with many of the physical therapists present.

Thanks go to Brian Werner and his group for inviting Dr. Epley to his clinic and allowing those of us present to view this new device.

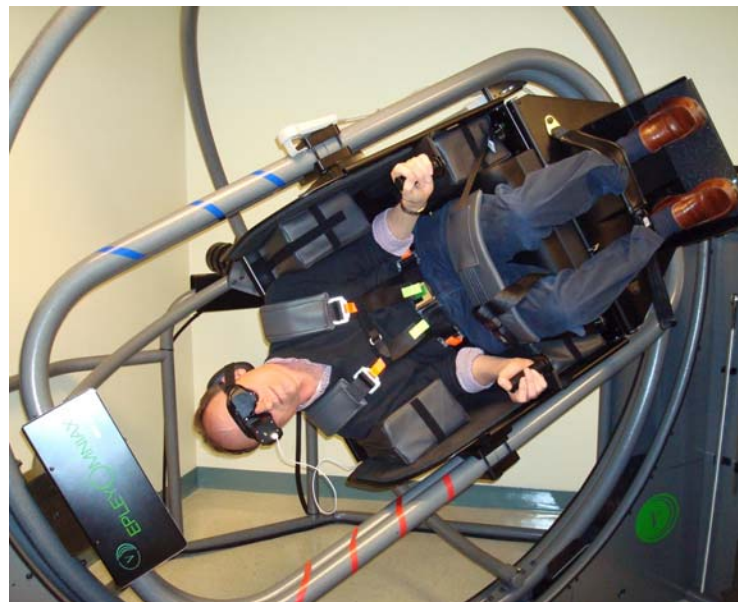


Figure: Dr. Rick Clendaniel in the Omniax device.

Thank you, Thank you, Thank you!!!

Michelle Gutierrez, PT
VR SIG Secretary

We had lots of fun at the Vestibular Rehabilitation SIG meeting at CSM this year. One aspect of the excitement was the **Raffle Giveaways**: Every attendee received a raffle ticket and many fantastic items were awarded to lucky attendees. We would like to acknowledge and thank the individuals who contributed to the Raffle giveaways this year.

- 👂 **Donovan Steutel/Science Audible** donated **5 JNPT podcasts**
- 👂 **Susan Herdman/FA Davis** donated **2 “Vestibular Rehabilitation, 3rd edition”** books, by Herdman
- 👂 **Joseph Furman** donated **“A Case Study Approach to Balance Disorders”**, by Furman and Cass
- 👂 **Joseph Furman and Sue Whitney** donated **“Neurotology”** by Furman and Whitney
- 👂 **Gary Jacobson/Plural Publishing** donated **“Balance Function Assessment and Management”** by Jacobson and Shepard
- 👂 **Alan Desmond** donated **“Vestibular Function: Evaluation and Treatment”** by Desmond
- 👂 **Linda Luxon/Informa Healthcare** donated **“Textbook of Audiological Medicine”**, by Luxon
- 👂 The **Vestibular Rehabilitation SIG** donated a **Disco Ball**

We are already panning for an even more exciting meeting next year at CSM 2010 in San Diego and have already confirmed donations from Micromedical Technologies for a pair of **infrared video goggles**, a **textbook** from Linda Luxon, and a Balance and Vestibular **exercise computer program** from VHI PC Kits. Don't miss out on the fun!!



DECISION 2009

Pat Winkler P.T. D.Sc., NCS
VR SIG Nominating Committee Chair

The nomination process for SIG positions closed March 13, 2009. Elections will open April 15th and will close May 15th. [Look out for communication from the Neurology Section on when and how to place your vote.](#) **Nominees are listed below:**

Secretary:
Michelle Guitierrez
Barbara Barker

Nominating Committee:
Anne Galgon
Julie Knoll
Becky Kellog-Olsen
Jennifer Nash

Thank you to all the candidates for your interest in serving the Vestibular SIG!



Practice and Billing Trends within Specialty Balance and Vestibular Programs

A Summary of Survey Results, *Marcia Hall Thompson PT, DPT and Denise Gobert, PT, MEd, PhD*

Poster Review by:
Michelle Gutierrez, PT
VR SIG Secretary

This poster, presented at CSM 2009, outlined a descriptive study looking at balance and vestibular practice and billing trends. It was a continuation from the programming on this topic at CSM 2008. The questions had been posed: *are physical therapists getting paid for what tests they do?*, and *are there inconsistencies in their practice and billing?* The authors, with support of the SIG and Texas State University at San Marcos, surveyed the membership to find out:

1. What assessment tests and measures are being used, from low tech to high tech?
2. For those tests used, what is being billed?
3. Were the evaluations across the ICF domains, as these measures were loosely divided into ICF categories?

In this descriptive look at what therapists are doing, the authors surveyed a sample of convenience of 164 physical therapists, mostly outpatient, and mostly experienced physical therapists. This survey seemed to be biased to the specialists in the field, as 60% percent had competency based post-graduate education in vestibular rehabilitation.

The demographic representation of the specialist was included. The majority of the respondents were US trained, with a PT degree, and >10 years experience practicing in outpatient hospital settings. There was representation of all payer sources across the nation.

Tests and measures were divided into 1. VOR impairment tests, 2. Balance impairment tests, 3. Life impact test and were analyzed relative to practice trends.

The majority of respondents used gait and balance function tests, however, a good number of clinicians are using special tests and measures, denoting the highly trained practitioners.

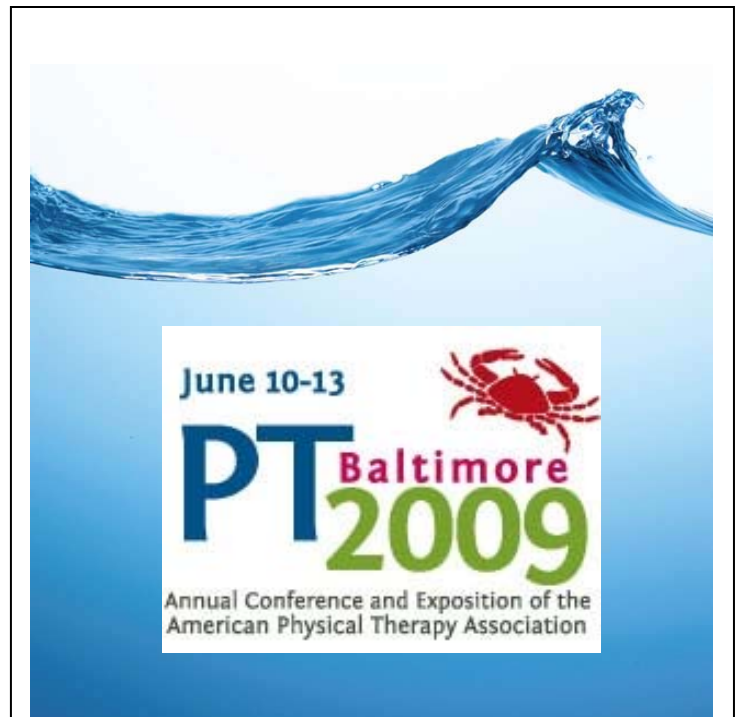
The most used CPT code was **97001** regardless of technology used. The second most used code was **97750** and it was used for computerized tests.

A chi square analysis was used for the level of training, years of experience and practice setting. Spearman's rho correlation analysis was used to further characterize the demographic information in relation to the test and billing code selected.

There was no statistical significance found between the selection of test or billing code choices and the years of clinical experience or degree. **There was a significant relationship between the advanced vestibular competency trained specialist and the test and billing codes selected.**

The authors found consistencies for the practice and billing, but not necessarily the findings that are needed. This means that PTs are not getting paid for what they perform. This also means that we can impact how therapists practice with post-professional education. The power is in the expert educators hands.

So where do we go from here? Marcia and Denise did a excellent job on this survey, so how do we get the information out, that we need to be using specialized billing codes for the special tests and measures that are above and beyond the tests normally used in the physical therapy evaluation? This discussion will continue....



Don't miss the Educational Programming at PT 2009 on **Vertigo and Dizziness: Ready for Direct Access?** Check out www.apta.org for more details!!!

Psychological Factors in Patients with Dizziness: *Concepts, Detection and Treatment*

Elizabeth Grace, PT, MS, NCS
VR SIG Newsletter Co-Editor

At CSM 2009 in Las Vegas, Jeffrey Staab, MD, MS and Elizabeth Grace, PT, MS, NCS presented programming on psychological factors in patients with dizziness. Dr. Staab is a psychiatrist at the Mayo Clinic in Rochester, MN who specializes in the treatment of patients with dizziness and psychiatric co-morbidity. Elizabeth Grace is a vestibular rehabilitation specialist who works at Good Shepherd Penn Partners in Philadelphia, PA and works extensively with this population.

Recent research has explored the relationship between symptoms of dizziness and imbalance and the effect of psychological factors such as anxiety disorders. In the early 2000s, Dr. Staab and his colleague at the University of Pennsylvania, Michael Ruckenstein, MD, began exploring this connection between anxiety and dizziness and introduced a syndrome they called **Chronic Subjective Dizziness**. Continued research in this area has demonstrated that 60% of patients diagnosed with Chronic Subjective Dizziness had anxiety that contributed to their chronic symptoms of dizziness.

So, how do you define Chronic Subjective Dizziness (CSD)? Patients with CSD often have a normal physical exam and imaging studies, although the exam may provoke symptoms, but not signs of vestibular dysfunction. In one's assessment of a patient, you can just **listen** for signs of behavioral morbidity, such as excessive avoidance behaviors and worrying. Behavioral morbidity is found in community settings at a frequency of 10-25% and in tertiary care settings 25-50%.

Key observations made in patients with CSD are:

- Persistent dizziness
- Vague description of 'dizziness'
- Hypersensitivity to self motion and visual movement/motion
- **Perception** of significant imbalance
- Provocation with visual challenges
- *Clinical impression of anxious temperament*

Psychological questionnaires that clinicians can use to assess this behavioral morbidity include the *Hospital Anxiety and Depression Scale (HADS)*, *Patient Health Questionnaire (PHQ-9)*, and the *Generalized Anxiety Disorder Scale (GAD-7)*. Recent studies support three interventions for patients with psychological problems and dizziness:

1. Newer classes of antidepressant medications (SSRIs and SSNIs)
2. Vestibular and balance rehabilitation therapy
3. Cognitive-behavioral psychotherapy

The most significant difference in vestibular rehab of patients with CSD is that the progression of rehabilitation **MUST** be slower than with typical vestibular patients. If you overstimulate these patients, their symptoms may worsen; they will **not** be compliant and will likely not return to therapy.

Additional key features of treatment with this population include:

- **Desensitization/Behavioral habituation**
 - NOT just compensation
- Reduce physical and psychological symptoms
- Extensive patient education
- SLOW, persistent approach to rehab
- Creativity in treatment

Additional resources on this topic for therapists and patients include:

- ❖ Staab, JP. Psychiatric origins of dizziness and vertigo. In: Jacobson GP, Shepard NT, eds., *Balance Function Assessment and Management*, 2008.
- ❖ Staab JP, Ruckenstein MJ. Expanding the differential diagnosis of chronic dizziness. *Arch Otolaryngol Head Neck Surg*. 2007; 133: 170-6.
- ❖ Ruckenstein MJ, Staab JP. Chronic Subjective Dizziness. *Otolaryngol Clin N Am*, 42 (2009) 71-77.
- ❖ Staab JP. Mastering Dizziness, Maintaining Balance. In: Dennis Poe, editor, *Consumer Handbook on Dizziness and Vertigo*.



Outcomes and Expectations for Patients with Vestibular Hypofunction

Julie Tilson, PT, DPT, NCS
VR SIG Vice Chair

Susan Herdman, PhD, PT, FAPTA gave an outstanding update on expectations for the best outcome among patients with unilateral vestibular hypofunction (UVH) at CSM 2009. She presented new data from 142 individuals with UVH treated using vestibular adaptation and substitution. Outcome measures included visual analog score for oscillopsia, perceived disequilibrium, Activities Balance Confidence Scale, dynamic visual acuity, gait speed, and Dizziness Handicap Inventory. For each measure, approximately 70% of patients improved.

Improvement, however, was not consistent across outcome measures. Additionally, patients' initial subjective complaints were predictive of subjective outcomes, whereas initial objective measures predict outcome on objective measures.

A few take home messages were: 1) Most, but not all, patients with UVH, get better; 2) Whether or not people are identified as 'better' depends on the outcomes measured; therefore it is best to measure a variety of outcome measures; and finally 3) more work is needed to determine effective interventions for the 30% or so of patients who do not get better.

Arriving at a PT Diagnosis for Patients with complaints of dizziness

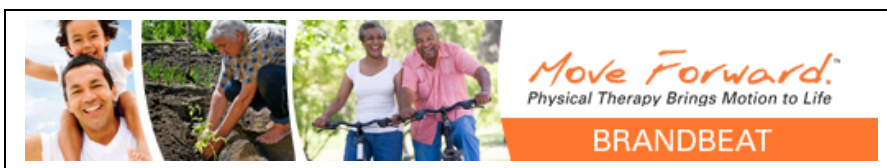
Jeffrey Hoder, PT, DPT, NCS
Assistant Professor
Emory University

To close CSM 2009 in Las Vegas, at our Vestibular SIG meeting this year, Susan Herdman, PhD, PT, FAPTA presented a talk on "Arriving at a PT Diagnosis for Patients with Complaints of Dizziness." She introduced the audience to a modified version of the clinical decision making paradigm that is published in her text "Vestibular Rehabilitation." (FA Davis, 2007).

The clinical decision making tree was designed to assist the clinician identify the possible underlying cause of a client's complaints of dizziness, as well as identifying those causes which may be amenable to physical therapy interventions versus those that suggest referral back to the physician. When arriving at an appropriate PT diagnosis, Dr. Herdman stressed the importance of taking a thorough patient history, being sure to clearly define the patient's **symptoms**, the **tempo** or duration of those symptoms, and the **circumstance** or provocative nature of the symptoms.

That history should be coupled with our clinical assessment, particular to Vestibular Rehabilitation, including oculomotor assessment, positional testing, head impulse testing and neck torsion testing. Using the history combined with our clinical test results, the paradigm can act as a guide to assist with interpretation of the results to aid the clinician's decision making process.

Case studies were then presented with videos of eye movements, as the audience was guided through the decision-making paradigm. She reiterated that the flowchart should **aid** clinical judgment, **not replace it**, as she presented various circumstances which may inadvertently mislead the therapist down the wrong clinical pathway on the decision making tree. The lecture was informative and engaging and reiterated the need for skilled and highly-trained professionals working with this patient population. We will look for her updated clinical decision-making paradigm, introduced at CSM, to be published in the near future!



For more information on the new APTA brand, go to www.apta.org/brandbeat

What does *every* therapist need to know?

Summary of Roundtable Discussion, CSM 2009,

Facilitators Julie Tilson, PT, DPT, NCS and Ray Hedenberg, PT

Julie Tilson, PT, DPT, NCS
VR SIG Vice Chair

A lively group of twenty vestibular rehab (VR) therapists joined the 2009 Roundtable on the final day of CSM. Our purpose was to exchange ideas about defining competency criteria for all therapists who will encounter persons with vestibular dysfunction. The group consisted of experienced and novice VR therapists with neurologic and orthopedic specialty training, PT program faculty, and VR researchers.

The group emphasized that therapists and students new to VR need:

- A framework for interpreting special tests of vestibular function
- To be able to triage central vs. peripheral signs and symptoms
- History taking skills that allow them to link:
 - Patient presentation → Appropriate tests and measures; and
 - Exam results → Appropriate management plan
- Case studies, preferably with video of the patient describing their symptoms, to illustrate the unique presentation features of persons with vestibular dysfunction

Co-facilitator, Ray Hedenberg, PT, shared a draft functional classification system for patients with balance and mobility dysfunction. The classification system emphasized the importance of considering the functional presentation of persons with vestibular dysfunction to guide treatment.

A previous Roundtable discussion at CSM 2003 outlined key VR history/interview questions, intervention techniques, physical examination components, vestibular disorders, physiologic and anatomical concepts, and minimum/ideal VR lecture and lab hours recommended for entry-level VR curricula (see Guidelines to Vestibular Evaluation/Treatment at www.neuropt.org/go/special-interest-groups/vestibular-rehabilitaiton/resources) The 2009 group generally agreed with this outline, however, the group suggested that levels of competency should be established for therapists/students with increasing responsibility for treating persons with vestibular disorders. The following levels were shared as an example from Sharp Health Care in San Diego, CA:

- Level 1: Ability to screen for peripheral and central signs/symptoms of vestibular dysfunction and refer appropriately
- Level 2: Ability to evaluate and treat BPPV
- Level 3: Ability to evaluate and treat diverse vestibular disorders

From our discussion, it was clear that continued work is needed to identify and disseminate core competency criteria for Vestibular Rehab skills among physical therapists.



VR SIG Website update

Laura Morris, PT, NCS
VR SIG WebMaster

The vestibular SIG website is a great place to get the latest news about what is happening! We have changed the format, with a "News and Noteworthy" tab, which allows members to find out the latest on such hot topics as CPT code issues, CSM news, and upcoming events.

Don't forget that there is a Vestibular Database on the site, which can help you find therapists to see your patients in Florida for the winter or Montana in the summer! Hopefully we will be rolling out a new, interactive map to help find therapists more easily. Stay tuned!

If you have any information that you would like to have added to the website, feedback about content or changes to the database, please don't hesitate to contact Laura Morris, WebMaster, at ptforbalance@gmail.com, or (703) 370-0274.

CSM 2010 San Diego

By Susan L. Whitney,
PhD, PT, NCS, ATC, FAPTA
VR SIG Chair

We are hoping that you are beginning to think about CSM 2010 in San Diego. We already have 3 donations that have been made for our Vestibular SIG meeting. **Micromedical Technologies** has agreed to donate a **pair of infrared goggles** as the grand prize for next year's SIG meeting. We are very excited about this great opportunity for one of our members to go home with a pair of infrared goggles!!! In addition, we have a copy of the **Linda Luxon book** entitled "**Textbook of Audiological Medicine**". We have also received a donation from **VHI PC Kits** for an **electronic Balance and Vestibular exercise kit**. We are hoping to obtain many more prizes for the SIG meeting next year and how to see all of you there. San Diego is a great town and it should be even warmer than Las Vegas.



We will keep you posted over the next few months of other prizes that we will be awarding at the SIG meeting. We plan to reward people who are members of the SIG with more opportunities to win the prizes by giving you extra tickets. It is simple to join the SIG- just contact our webmaster Laura Morris at ptforbalance@gmail.com. She will sign you up or you can go to the Neurology Section web site and sign on yourself. If you are not sure you are listed as a SIG member, just check with Laura. One of the goals of the Vestibular SIG is to increase SIG membership by 25%. We hope that you will sign on and join us.

