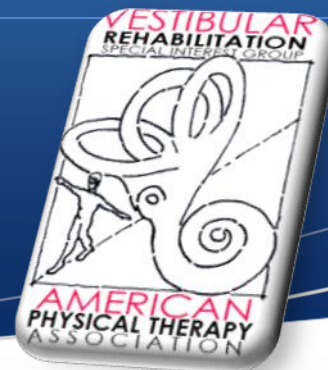


Vestibular Rehabilitation SIG

American Physical Therapy Association/Neurology Section

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Message from the Chair

Anne K. Galgon, PT, PhD, NCS

Vestibular Rehab SIG Chair

VR SIG in It's 20th Year of Service!

This spring newsletter will feature Vestibular Rehabilitation (VR) SIG related events and programs at CSM 2015. CSM was a great success for the members of the VR SIG. All of the Vestibular programming sessions were completely full and we had several hundred attend our business meeting. I am in awe of the number of attendees and the amount of interest in Vestibular Rehabilitation. It has been evident over the last several years that vestibular rehabilitation practice has broadened and has utility in multiple areas of physical therapy practice. This is evident in the CSM educational program as many topics fall outside of traditional vestibular rehab clinical practices, including pediatrics, acute care, concussions, cervicogenic dizziness to name a few. Dr. Rose Marie Rine, who pointed out that children with vestibular related deficits are underserved and vestibular therapists have the skill set to evaluate and treat these individuals, emphasized the growing need for vestibular therapists in the pediatric program session. At our SIG business

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For more information go to:
<http://www.neuropt.org/go/special-interest-groups/vestibular-rehabilitation>



Coding Challenge

CPT 95992: Denial of Payment

Lisa Dransfield, PT, DPT, NCS • Nominating Committee

THE CHALLENGE:

Denial of payment when using Canalith Re-positioning (CPT Code 95992) to bill for treatment of BPPV has been an ongoing problem for many Physical Therapists throughout the United States.

THE SOLUTION

A number of factors must be considered to determine the reason for the denial. Understanding that the practice setting and state in which the service is delivered affects the reimbursement and timely payment for the treatment is key. Fee schedules also vary among states; for example, an outpatient clinic in Texas that provides both audiology and physical therapy, tracked the usage and reimbursement of the code in 2014. The code was billed 600 times with an average reimbursement of \$33.33. In an outpatient multidisciplinary vestibular clinic in Connecticut, the code was billed 759 times in 2014, for an average reimbursement of \$48.36.

Reportedly, Medicare in Georgia does not pay for Canalith Re-positioning; whereas, Medicare in Connecticut does, at a rate of \$36.78. In Connecticut, as in 9 other states, Medicare is administered by the National Government Services (processes approximately 20 percent of the nation's Medicare Claims) and proper billing is mandatory for timely reimbursement of CPT 95992. It must be linked with a diagnosis of BPPV and if additional procedural codes are used in the same treatment, a modifier may need to be added to the additional code.

Knowing these factors and your practice setting can provide you with the information in determining reasons for your denials. Reference: <http://www.ngsservices.com/claims.html>

CODING CHALLENGES with Canalith Repositioning Maneuver CPT 95992

The Vestibular Special Interest group would like to invite clinicians to share their billing and reimbursement challenges with CPT code, 95992. Our team members will assist in problem- solving to optimize reimbursement and ensure that the code is being used appropriately. We will showcase different issues and solutions related to usage of the code in our Newsletter and on our website.

Therapists are encouraged to describe their experiences with CPT CODE-95992 by contacting Lisa at mld661@sbcglobal.net.



COMBINED SECTIONS MEETING 2015

Visual Dysfunction following Concussion

By **Lisa Dransfield PT, DPT, NCS • Nominating Committee**

The Vestibular Special Interest Group of the Neurology Section sponsored a valuable and timely presentation on “Evaluation and Treatment of Visual Dysfunction Following Concussion,” at CSM, 2015. Presenters Anne Mucha, DPT, MS, NCS and Nathan W. Steinhafel, MS, O.D., F.A.A.O delivered an informative discussion on common visual system impairments following mild Traumatic Brain Injury/ Concussion and the role of the vestibular physical therapist in the examination and treatment of visual impairments. Optimal function of the vestibular system is dependent on normal binocular vision, and the vestibular therapist possesses the necessary training and skill to assess the vestibular system and manage the concussed patient with visual function issues. Additionally, Dr. Mucha proposed that the role of the vestibular physical therapist in vision assessment after concussion is that of “gatekeeper,” recognizing when to treat simple visual dysfunction and when referral to an eye care specialist is warranted. Dr. Steinhafel, an optometrist, described the optometric/ophthalmology examination and how to identify dysfunction in the 4 areas of binocular vision.

The Vestibular/Ocular Motor Screen or “VOMS” was introduced as a brief assessment tool of visual-vestibular function post- concussion, the results of which can guide referral and treatment. Finally, treatment techniques for mild convergence insufficiency, pursuit and saccades abnormalities were presented to improve vision skills in the patient with concussion.

The seminar was well attended with standing room only in the venue, and preceded the Vestibular Special Interest Group’s business meeting.

JOIN THE CONVERSATION!!

The Vestibular Rehab SIG is actively involved in social media. Find us on Facebook at Vestibular Rehab SIG and on Twitter @VestibularRehab. Following the SIG on social media is a great way to stay up to date on the latest vestibular research, connect with the vestibular rehab community, and become an active member of the group.

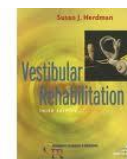


2015 VRSIG BUSINESS MEETING GIVE-AWAYS

There is plenty of fun each year at the VRSIG Business Meeting and this year was no exception. Every attendee received a raffle ticket upon entering for their chance at winning one of the **Raffle Give-Away prizes** donated by generous supporters of the VRSIG. This year there was a new prize offered titled ***“Day with the Expert.”*** The lucky winner of this prize has the opportunity to spend a day shadowing and learning from a Vestibular Rehab Expert. The VRSIG would also like to say a special *“Thank You”* to **Mary Kay Rohrkemper**, who did not use the Micromedical Goggles she won last year and donated them back this year to allow for another lucky winner to take them home. **We would like to acknowledge and send a sincere thank you to the individuals and companies, listed below, who generously contributed to the Raffle Give-Aways this year!**

AND THE WINNERS ARE...

- 👂 Nicole VanHeuklon and Betsy Grace Georgelos each won **Micromedical InView Goggles.** (<http://www.micromedical.com>)
- 👂 Monica Diamond won **VHI Vestibular and Balance Exercise kits.** (<http://www.vhikits.com>)
- 👂 Mark Boland, Nichole Ponda, Brittany Kennedy and Kyle Butzine each won **Neuro Note: Clinical Pocket Guide from FA Davis Publishing**
- 👂 Jessica Schwartz won **“Follow the Expert” with Sue Whitney, DPT, PhD, NCS, ATC, FAPTA**
- 👂 Rachel Trommullen won **“Follow the Expert” with Michael Schubert, PT, PhD**
- 👂 Laura Martin won **“Follow the Expert” with Janene Holmberg, PT, DPT, NCS**
- 👂 Catherine Kestner won ***“Balance Function Assessment and Management”*** by Gary Jacobson and Neil Shepard from Plural Publishing (http://www.pluralpublishing.com/publication_bfaam.htm)
- 👂 Kevin Kuhns and Worth Saunders each won a 1 year membership to VEDA (<http://www.vestibular.org>)
- 👂 Jenny Tanaka and Jennifer Yue each won ***“Vestibular Rehabilitation, 4th Edition”*** by Susan Herdman, PT, PhD, FAPTA, from FA Davis Publishing





Pediatric Considerations for Vestibular Balance Therapy

By Jennifer Braswell Christy, PT, PhD

Your favorite otolaryngologist calls with a special referral. A 7-year-old child who had bacterial meningitis at age 4 years received aggressive antibiotic treatment resulting in profound bilateral hearing loss. His mother reports previous dizziness, which resolved and is concerned that her son is not able to keep up with his peers while playing sports and is falling behind in school. You have reservations about taking this patient since your current toolbox of head thrust, Dynamic Visual Acuity (DVA), Dynamic Gait Index (DGI) and Modified Clinical Test of Sensory Interaction on Balance (mCTSIB) probably aren't valid and reliable for this patient. You also wonder how to get a 7- year-old to do the eye-head movement exercises every day. However, being the amazing evidence based clinician that you are, you quickly search PubMed and find the latest article in Pediatric Physical Therapy by Christy et al. 2014 describing reliability and validity of vestibular tests for children. You also find some earlier articles by Rine and Braswell (2004 and 2006) describing and testing modifications of vestibular balance exercises so that they are fundamental, functional and fun for children. Challenge accepted!

Vestibular related impairments in children are more common than previously thought, yet often go undiagnosed and subsequently, these children are not referred to therapists for vestibular balance

therapy. Common causes of vertigo and imbalance in children include benign paroxysmal vertigo of childhood, migraine equivalent, neuronitis, and otitis media with effusion (Riina 2005). Mild TBI is also common in young children and adolescents which can cause chronic symptoms of dizziness and imbalance (McCaslin 2011). Children with severe to profound sensorineural hearing loss may have related vestibular hypofunction, similar to the patient mentioned previously, causing progressive developmental delays and poor balance reactions, warranting intervention (Rine 2004). Children treated with ototoxic medications for cancer or cystic fibrosis might also be at risk for vestibular dysfunction. Therefore, it is important that therapists trained in vestibular therapy be prepared and willing to test and treat children.

When assessing a child or infant with suspected vestibular impairments, the therapist should interview the parent and child to determine symptoms, tempo and circumstance. In the absence of formal developmental testing, the clinician should obtain a developmental history to include milestones of sitting and walking. Children with vestibular hypofunction have difficulty in challenging balance situations.

Therefore, the therapist should ask how the child responds to challenging situations

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VRSIG Newsletter Article of the Year!

The Co-Editors of the VRSIG Newsletter would like to Congratulate **Britta Smith PT and Colin Grove PT, MS, NCS** for authoring the newsletter article of the year entitled ***“Vestibular Rehabilitation in Acute Care.”*** This award is decided by a panel of reviewers from the SIG leadership team, which evaluates articles on the following criteria:

- The article is written clearly and concisely
- There is a clear theoretical basis for the article
- The review of literature and introductory statements provide evidence for the importance of the article to physical therapy and it makes an important contribution to the understanding of clinical practice and patient care
- The article provides information that can assist others in the delivery of physical therapy services.
- The article contains clear descriptions of clinical procedures or describes approaches that can be understood by others and contains supportive rationales for the approaches used and elements of the article with sufficient clarity to permit replication.



At the Business Meeting in Indianapolis, the VRSIG had an opportunity to acknowledge Britta and Colin for their hard work and willingness to support the SIG in providing knowledge in an emerging practice setting for Vestibular Rehabilitation. Thank you Britta and Colin!

CALL FOR NEWSLETTER ARTICLE WRITERS!!!

Do you want to get involved with your SIG? Consider writing an article for the newsletter!! You can write on a topic of your choosing or an appropriate topic could be assigned to you. If you are interested in getting involved with the newsletter, please contact Betsy Grace Georgelos at Elizabeth.grace@uphs.upenn.edu or Debbie Struiksma PT, NCS at dstruiksma77@aol.com.

Service to the VRSIG Award: Laura Morris

Michelle Gutierrez, PT, DSc • Website Chair

This year the Vestibular Rehabilitation SIG awarded the **Service to the SIG Award** to **Laura O. Morris, PT, NCS**. Laura has been an integral part of the SIG since she was elected to nominating committee in 2002. She served as nominating committee member and as chair, was on the Advanced Vestibular Rehabilitation Course Planning Team, has written 7 Patient Fact Sheets, and she has been a podcast presenter. Most notably, Laura has been the website coordinator since 2006 until she was elected to Director of Communications for the Neurology Section in 2014. She was instrumental in



making our website very useful to the Vestibular Rehabilitation SIG members. Laura started this position with a webpage and quickly realized the way to keep people engaged in the website is by constantly updating and refreshing the content. Under her direction of the website she kept the information on the website fresh, she helped develop the Map of Vestibular Rehabilitation Providers, added many videos and links to information that therapists and patients find valuable. Due to Laura's appealing design, at one point the total number of visits to the Vestibular Rehabilitation SIG webpage was more than any other SIG and just less than the Neurology Section's home page. Since her departure as the SIG Website Coordinator she has continued to work

with the Clinical Practice Guideline Group and continues to consult with the VRSIG regarding various website expansions. She has spent many, many hours and many long evenings making the vision for the VRSIG website in 2006 into a reality. She is now able to share her website experience with the rest of the section. Although she has moved to the Neurology Section leadership team, the SIG nominated her as the recipient for all the work she has accomplished and will continue to achieve for the Vestibular Rehabilitation SIG. Thank you Laura for all of your hard work!

Janet Helmski Wins Jack Walker Publication Award!

Janet Helmski PT Ph of Midwestern University in Chicago is the recipient of the APTA's 2015 Jack Walker Publication Award for her paper ***Effectiveness of the canalith repositioning procedure in the treatment of benign paroxysmal positional vertigo. Phys Ther.***

2014;94(10):1373-82. The award will be presented at the APTA NEXT Conference in June. We encourage all members who are planning to attend to cheer her on. The VRSIG would like to thank Janet for her many contributions including educational courses, CSM presentations and writing articles for our Newsletters. The SIG is so pleased that she has been recognized for her contribution to vestibular rehabilitation!





VRSIG Presents Slate for 2015 Election

Lisa Heusel-Gillig PT, DPT, NCS • Nominating Committee Chair

The VR SIG Nominating Committee is excited to present a slate of qualified candidates who have offered their time and service to the SIG. Elections are held electronically and began in April with polls closing taking on May 15. The election results are in and can be found on the Neurology Section website. However, the SIG would like to acknowledge all of the well qualified candidates that were willing to participate in this year's election and give of their time. Their willingness to volunteer is what makes the VRSIG accomplish all that it does each and every year.

2015 Nominees Are:



Secretary

Janene Holmberg PT, DPT, NCS is the coordinator of Balance Rehabilitation, Intermountain Hearing and Balance Center in Salt Lake City, Utah as well as auxiliary Faculty at University of Utah. She is a national lecturer on Vestibular Rehabilitation and has served as secretary of the Vestibular SIG since 2012.

Christina Dunlea PT, DPT is a clinical specialist at Brigham and Women's Hospital at BWH/MGH Healthcare Center in Foxborough, Massachusetts. She is also a lab instructor/adjunct faculty at Northeastern University. She presents frequently at local and national conferences.



Nominating Committee

Karen Skop PT, DPT is a clinical specialist in vestibular rehabilitation and concussion/post deployment program at James Haley in Virginia. She has lectured and published in areas of concussion, blast injuries and vestibular rehabilitation

Meleah Murphy PT, DPT works at the Cleveland Clinic, Lou Ruvo Center for Brain Health in Las Vegas, Nevada. Her practice focuses on patients with neurodegenerative diseases and she provides vestibular assessments on retired professional athletes who have sustained multiple concussions. She is also working on integrating vestibular function testing to optimize treatment in patients with neurologic disorders. She serves as the secretary of the Nevada APTA Southern District.

We would like to sincerely thank all of the candidates for their interest in serving the Vestibular Rehab SIG! And would like to congratulate our newly elected leadership, **Janene Holmberg and Karen Skop!!**



Pediatric Considerations

Continued from page 5

(e.g. riding a two-wheeled bicycle, walking on a balance beam, playing sports, negotiating stairs). A good question to ask is whether or not the child is able to do activities as well as other children of the same age. Currently, no reliable and valid standardized tools exist to measure the impact of dizziness in children, although a pediatric version of the Dizziness Handicap Inventory and a questionnaire to screen for vestibular related symptoms are being developed.

The objective tests for functional use of the vestibular system in children was recently validated on 20 children with severe to profound sensorineural hearing loss, aged 6-12 years (Christy 2014). The Clinical DVA Test had good test-retest reliability (ICC=0.81), sensitivity (88%) and specificity (69%) to identify children with hypofunction (Rine 2003; Christy 2014). The Lea symbols chart should be used for the DVA test with one trial of static and two trials of dynamic testing. The cut-off score to identify potential hypofunction is similar to adults (>2 lines of difference or >10 optotypes difference between static and dynamic). If doing intervention to improve gaze stability, the minimal detectable change score was 8 optotypes. If the child is cooperative, the DVA can be completed on children as young as three years of age (Rine 2003). The head thrust test (HTT) was also reliable (ICC=0.73), sensitive (75%) and specific (77%) to identify hypofunction with two or more positive responses after completing 3 trials to each side in random order. Although reliable (ICC=0.74), the validity of the bucket test was inconclusive since children with hypofunction did not have abnormal scores. This might be a good test for children with suspected central vestibular problems.

Postural control develops throughout childhood with vestibular effectiveness not maturing until after age 15 years (Ferber-Viart 2007). In the study by Christy et al. 2014, children aged 6-12 who scored < 0.20 on the vestibular ratio (condition 5/1 on the sensory organization test) were identified as having hypofunction with 88% sensitivity and 92% specificity. Test retest reliability of the mCTSIB was ICC=0.74 if all four conditions were completed, using the average score (in seconds) of three trials per condition, for a total possible score of 120. A score of <110 seconds was 88% sensitive and 85% specific for hypofunction. If doing balance interventions, the minimal detectable change score for the mCTSIB was 16.75 seconds. Therefore, it is recommended that clinicians perform the HTT, DVA and mCTSIB or SOT to identify children who might have hypofunction (Christy 2014), and then retest with the DVA and mCTSIB to determine response to intervention.

Vestibular balance therapy for children must be **FUNDAMENTAL, FUNCTIONAL AND FUN**. Clinicians trained in vestibular science should remember the **FUNDAMENTAL** theories of treatment to include adaptation, substitution and habitation. The basic exercises should be modified to be **FUNCTIONAL** and **FUN**, and



Pediatric Considerations

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Incorporated into the DAILY life of the child. For example, instead of giving a child a card with one letter on it for X1 viewing (BORING), find a book that they are reading in school and have them read while moving their head (FUNCTIONAL). Head movement can be self-generated, or can be imposed by having the child walk on a treadmill or jump on a mini-trampoline (note the added bonus of cardiovascular training). Since children with profound bilateral hypofunction do not get dizzy, they can spin on a "sit and spin" and identify words on flash cards (FUN). The younger child who cannot read can be asked to choose a certain small stickers while the parent is bouncing them on their lap or swinging them in a swing. Balance exercises should be challenging and should include tandem walking, walking on balance beams and soft surfaces, and maintaining balance with low light or with eyes closed. Treatment of motion sensitivity, after all other causes have been ruled out, should be done similar to habituation treatment in adults. Determine the movement that makes the child symptomatic, then start slowly and build up to the activity after thousands of repetitions over time. All exercises should be done every day and incorporated into the life routine.

Braswell J, Rine RM. Evidence that vestibular hypofunction affects reading acuity in children. *International Journal of Pediatric Otorhinolaryngology*. 2006;70:1957-1965.

Braswell J, Rine RM. Preliminary evidence of improved gaze stability following exercise in two children with vestibular hypofunction. *Int J Pediatr Otorhinolaryngol*. 2006;70(11):1967-1973.

Christy JB, Payne J, Azuero A, Formby C. Reliability and diagnostic accuracy of clinical tests of vestibular function for children. *Pediatric Physical Therapy*. 2014;26:180-190.

Ferber-Viart C, Onescu E, Orlet T, Roehlich P, Ubreuil C. Balance in healthy individuals assessed with Equitest: maturation and normative data for children and young adults. *International Journal of Pediatric Otorhinolaryngology* 2007;71(7):1041-1046.

McCaslin DL, Jacobson GP, Gruenwald JM. The predominant forms of vertigo in children and their associated findings on balance function testing. *Otolaryngol Clin North Am*. 2011;44(2):291-307.

Rine RM, Braswell J. A clinical test of dynamic visual acuity for children. *Internat J Ped Otorhinolaryng*. 2003;69(11):1195-1201.

Rine RM, Braswell J, Fisher D, Joyce K, Kalar K, Shaffer M. Improvement of motor development and postural control following intervention in children with sensorineural hearing loss and vestibular impairment. *Internat J Ped Otorhinolaryng*. 2004;68(9):1141-1148.

Riina N, Ilmari P, Kentala E. Vertigo and imbalance in children: a retrospective study in a Helsinki University otorhinolaryngology clinic. *Arch Otolaryngol Head Neck Surg*. 2005;131(11):996-1000.



Message from the Chair

(Continued from page 1)

Meeting I was honored to be able to present the accomplishment and future plans and recognize individuals who have contributed to the SIG's achievements. I want to thank all of the SIG leadership, raffle items donators, speakers and attendees who played a role in a successful meeting.

The VR SIG is in its 20th year of serving physical therapists that manage individuals with vestibular and balance disorders. Over the next year we hope to highlight the history of the VR SIG and celebrate the contributions of individuals who developed and moved our group forward. Please feel free to share photo, memories or experiences you have had with the SIG over the last 20 years with any of the VR SIG leaders. We plan to culminate this celebration at **CSM 2016 in Anaheim, California**. Start making your plans to attend!

The biggest factor that contributes to the success of the VR SIG over the last 20 years is the **participation** of our members. Participation can be many things, from serving in leadership roles, to working committees and work groups, writing newsletter articles, attending programming, utilizing our resources, or providing us with feedback on our efforts. I am always happy to talk with members about our efforts and ways to participate. Below I have highlighted important actions that all of the members can participate in right now with no big time commitment. Even these small measures of participation can help shape the VR practice in the future. I encourage you all to check these opportunities out at <http://www.neuropt.org/special-interest-groups/vestibular-rehabilitation/new-and-noteworthy>.

1) The Neurology Section supported our SIG members to develop a **Clinical Practice Guideline on the management of Vestibular Hypofunction**. This is historic because it is the first CPG produced by the section. What is really important is the draft of the CPG is now available for public comment. Please go to the Vestibular Rehabilitation SIG News and noteworthy page. Read this document and

provide feedback. This is an essential step in the process to complete the CPG. The CPG is valuable because it not only provides a standard for our clinical practice; it helps to identify research areas that are needed to advance our practice. I want to thank the members of the task force, Drs Courtney Hall, Susan Herdman, and Sue Whitney, who worked so hard to put this CPG together.

2) The **Vestibular Rehabilitation Practice Analysis Task Force** has also been working to define Vestibular Rehabilitation Practice. This group has been seeking signatures from members to support a petition to have Vestibular Rehabilitation Specialization through ABPTS. Signature pages and instructions on how to submit your signature are also available on the News and noteworthy page, under the title "We are EXCITED TO SAY WE NEED YOUR HELP."

<http://www.neuropt.org/special-interest-groups/vestibular-rehabilitation/new-and-noteworthy>
Many thanks to Becky Olson-Kellogg and Rebecca English, who have been working hard and representing the SIG on this task force. Over the next year the task force will begin to survey clinicians to support the description of advance practice in vestibular rehabilitation. Participation in these surveys will be crucial to move this process forward as well.

3) **The SIG would like to know how we could serve you better**. Shortly, we will be surveying the members for feedback on the resources, education and news updates that we provide. As the available evidence for vestibular rehabilitation and technology is rapidly changing, there are probably new formats for providing resources, education and news to our member. You will be able to find notifications about the survey in several ways including the webpage, the abstract of the week, facebook and twitter. I encourage all members to participate. Spending a few minutes filling out the survey and providing comment will likely have great influence on the activities of the SIG over the next few years.