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LCD for VESTIBULAR Function Testing (L28314)

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01102

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VESTIBULAR Function Testing

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J1B-08-0086-L

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Title XVIII of the Social Security Act (SSA), §1862(a)(7), states that Medicare will not cover any services or procedures associated with routine physical checkups.

Title XVIII of the Social Security Act, §1862(a)(1)(A), allows coverage and payment for only those services that are considered reasonable and necessary.

Title XVIII of the Social Security Act, §1833(e), prohibits Medicare payment for any claim that lacks the necessary information to process that claim.

Title XVIII of the Social Security Act, §1861(II)(2) explains that the diagnostic tests for which Medicare payment may be made to audiologists include hearing and balance assessment services.

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§80.3 and 80.3.1 (CR1573, CR2073), describe coverage for hearing and balance studies. They also define a "qualified audiologist".

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 3, §3.4.1.2, explains that when contractors cannot make a coverage or coding determination based upon information on a claim, that they may issue an additional documentation request (ADR) to the referring provider (in addition to the billing provider).

Title 42 of the Code of Federal Regulations, §§410.32 and 410.33 describe conditions of coverage for diagnostic tests.

HCFA Ruling 95-1 is binding on providers, contractors, appeal levels, and an Administrative Law Judge. Ruling 95-1 describes limitations on the usage of limitation of liability (SSA, §1879). For example, care which exceeds community standards is known to be not payable by Medicare.

CMS Manual System, Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3, §3.4.1.1.E, states that contractors may require ICD-9 diagnosis codes to be submitted by all providers, with every claim for a targeted service if such a requirement appears in a LCD for that service.

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This policy addresses diagnostic testing of the vestibular system. Vestibular tests are tests of function, designed to identify a potential cause of balance problems. Their purpose is to determine if there is a problem with the vestibular portion of the brainstem and inner ear. Studies have documented that in appropriate clinical settings, vestibular tests are more accurate than clinical examination in identifying these disorders. The appropriate clinical setting is described in this policy, including careful evaluation of the patient, rationale for ordering high quality tests, clear communication between the treating physician, consulting physician, and audiologist, interpretation in light of the patient's case, and a plan for use of the results in the patient's care. Diagnostic tests are not payable by Medicare unless directly used in the patient's care.

Vestibular function testing is covered for the purpose of determining the appropriate medical or surgical treatment of disorders in the vestibular system. Other causes of balance problems can be found in other systems including the senses of sight and touch, proprioception, muscle movement, and from the integration of the sensory input by the cerebellum. Causes of balance problems can also include low blood pressure, including postural hypotension, asymmetrical gait due to pain, poor vision, poorly fitting shoes, lack of concentration on safety in the immediate environment, anxiety, and others.

This policy is being developed in part due to the number of services for vestibular function tests found by the outgoing contractor as being three times the national average, per 1000 beneficiaries. Roughly two thirds of the services are provided by Independent Diagnostic Testing Facilities (IDTFs). Utilization alone does not shape policy, rather, medical review has found high numbers of inappropriate and unnecessary tests. In this policy, the reasonable and necessary aspects of these tests will be emphasized to help the provider understand what this A/B MAC will and will not cover.

VESTIBULAR TESTING

When a patient presents with complaints of balance problems, a thorough history should be taken, a complete physical examination should be conducted and a thorough review of medications should be completed. These expected medical activities can often elicit a likely cause of the problem. A complete picture of the patient is necessary before testing decisions can be made. The tests that would identify a common cause of balance problems should be conducted first, with progression in testing toward the least common cause of balance problems.

For example, an ECG may show bradycardias or heartblocks. A series of blood pressure checks may show a pattern related to medication intake time. The patient may be taking more (or less) medication than ordered because he/she didn't understand the dosing instructions.

If the provider sees or suspects a cause that would warrant a referral to a specialist, a referral would be expected. For example, if an ECG showed cardiac rhythm abnormalities, a referral to Cardiology would be expected. Any neurological findings on physical examination could warrant a referral to a neurologist, neurosurgeon, neurotologist, or similar specialist. In these cases, ordering vestibular function tests would likely not be warranted when a nonvestibular cause of the balance problem was discovered and treated via the referral.

Treating Physician / Billing Provider

As noted above, vestibular function tests are covered by Medicare only where it is clinically necessary to rule in or rule out diagnoses of vestibular disorders. A test is clinically necessary when there is (A) appropriate evaluation and justification prior to the test and (B) when the test is also likely to affect the course of therapy. In the case where the ordering/treating physician is not the billing entity, the tests may be ordered in writing only by the physician who is treating the beneficiary, that is, the physician who is (A) furnishing a consultation or (B) treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. The treating physician in question has a relationship with the beneficiary prior to the performance of the testing and is treating the beneficiary for a specific medical problem for which the tests are being ordered. Providers of vestibular testing should be aware that this A/B MAC has encountered high levels of vestibular testing which were found to be not medically necessary at the contractor, Hearing Officer, and Administrative Law Judge level.

Evaluation: Again, there must be a clinically appropriate evaluation of the patient (history, physical and medication review) prior to any tests being ordered. In the case where the billing provider for the tests is not the referring provider, Medicare may request full contact information for the referring provider, request appropriate evaluation and referral records from the referring provider, and deny payment for the test if no such records are provided or the records do not document the necessity of the test.

Course of therapy: A test is clinically necessary when it is likely to be used to select or change the course of therapy for the disease. For most patients, these tests will usually lead to forms of treatment such as head positioning exercises, medications, surgery or other clinically accepted interventions, by the treating physician, in the course of therapy for the disease discovered by testing.

Scope of Practice

Diagnostic procedures 92541 through 92548, as described below, may be performed only by licensed audiologists with a physician's order; by a licensed physician, preferably with certification by the American Board of Medical Specialties in Otolaryngology, Neurology or Otolaryngology/Neurology; or by personnel employed "incident to" a physician. Effective March 19, 2004, these procedures, when performed by personnel not qualified as described above, are not covered by this A/B MAC.

The following CPT codes for Vestibular Function Testing are covered by this policy:

92540 - Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording and oscillating tracking test, with recording

This test should not be billed with CPT codes 92541, 92542, 92544 or 92545 as they are included in this test.

92541 – Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording

This test may be billed along with CPT code 92542, and may be repeated in the presence of ongoing symptoms, to assess the impact of medical or surgical treatment. By "recording", the provider must store for future documentation by video or paper tracing, the eye movements observed. When treatment is successful in controlling the symptoms, no additional testing would be expected, unless symptoms return or worsen.

92542 – Positional nystagmus test, minimum of four positions, with recording. (Current Procedural Terminology (CPT) 2007)

This test may be billed along with CPT code 92541 and may be repeated in the presence of ongoing symptoms, to assess the impact of medical or surgical treatment. By "recording", the provider must store for future documentation by video or paper tracing, the eye movements observed. Problematic patients with variable, paroxysmal, or "crescendo" symptoms may require several tests over a period of weeks to establish e.g. the canal containing obstructions in benign positional vertigo and to confirm response to therapy. However, when treatment is successful in controlling the symptoms, no additional testing would be expected, unless symptoms return or worsen.

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

This test usually consists of four tests (a test in each ear for warm and cool and if need be two additional tests with ice water, which would make it a QB of 4-6). However, if a problem is identified early in the test, which matches the clinical picture, all 4-6 tests might not be needed. This test identifies asymmetry of function between the two sides. However, the stimulation parameters are such that it mimics only slow head movements. This limits the Caloric test to assessing one aspect of the vestibular system, and therefore, some cases of peripheral vestibular dysfunction may be missed by the test.

92544 – Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording

This test documents and measures eye movements as the patient watches a series of targets moving simultaneously to the right and then to the left. The optokinetic mechanism is at work when the visual movement in one direction encompasses a large field. This is a test of central vestibular function, and sensitivity to visual motion stimuli. It is very useful in the assessment of patients with visual motion-elicited dizziness, and is a good central function control test for other tests.

92545 – Oscillating tracking test, with recording

This test evaluates the ability of the patient to keep a moving visual target registered on the fovea. The patient watches a light as it moves back and forth in a smooth pendular fashion. The computer computes the gain (target velocity divided by eye velocity) and compares the gain to age matched norms. The test is a good measure of central function, and evaluates the integrity of cortical visual motion pathways as well as the cerebellum and pontomedullary brainstem. It is a useful adjunct to other central tests, such as the suppression subtests of the caloric test, since these regions and mechanisms are partially responsible for central control of vestibular input.

92546 – Sinusoidal vertical axis rotational testing (commonly called Rotational Chair Testing)

This test requires the use of a chair capable of rotating around a vertical axis. There are several models of an appropriate chair for this test. This test is NOT performed by having the patient sit or stand on any kind of substitute platform or surface. The report produced by a legitimate test will print the findings discussed below. This test is not a head-shake test.

When the chair is rotated in the dark, it induces nystagmus. The individual's eye movements are recorded during this rotation, and the velocity of the slow phase of the nystagmus is compared to the chair rotation at a variety of frequencies to derive a measure of the gain, or function of the vestibular system. The gain can be compared to established norms to determine if there is vestibular hypofunction or hyperfunction. When tested at higher velocities of rotation, it is possible to determine a measure of asymmetry (or unilateral weakness). The rotary chair test also allows one to determine the duration of the vestibular response through measures of the time constant. The interaction of the gain and time constant measures are useful in determining whether the vestibular loss is an acute or chronic condition. The rotary chair is the most useful method to document bilateral vestibular loss.

Because this CPT code shows, through data analysis, that it is frequently abused by not using proper equipment, this A/B MAC may ask for the manufacturer name and serial number with each claim.

92547 – (this is an add-on code) – Use of vertical electrodes (list separately in addition to code for primary procedure; use with 92541-92546)

If no tests are conducted that utilize electrodes, then this code should not be billed.

92548 – Computerized dynamic posturography

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.

Because this CPT code shows, through data analysis, that it is frequently abused by not using proper equipment, this A/B MAC may ask for the manufacturer name and serial number with each claim.

Vestibular function tests and/or diagnostic audiometric tests are covered when testing is for the purpose of determining the appropriate medical or surgical treatment for disorders of balance.

Dizziness (ICD-9-CM Code 780.4) may support the medical necessity for hearing tests in the initial otolaryngologic evaluation of patients in whom general medical causes (anemia, cardiovascular, metabolic, etc.) have been excluded. **However, since dizziness is a vague complaint, a diagnosis of dizziness alone does not qualify for coverage for vestibular function testing. There must be sufficient evaluation of the patient that vestibular testing is likely to contribute directly to the patient's therapy.** We would expect this documentation to be in the chart if requested.

When the medical conditions requiring medical or surgical treatment are already known by the physician, or are not under consideration, and the diagnostic services are performed only to determine the need for or the appropriate type of hearing aid, the services are statutorily excluded from Medicare coverage whether performed by a physician or nonphysician.

HEARING TESTING

Standard hearing tests are not addressed in this policy. However, when a hearing test is ordered as a basis from which to decide to conduct vestibular testing (the provider may suspect a vestibular problem but wants to rule out a pathology other than normal age-related hearing loss), the hearing test will be covered.

Diagnostic audiologic testing (including hearing and balance assessment services) is covered when performed by a physician or a qualified audiologist. A qualified audiologist is an individual with a master's or doctoral degree in audiology and who is licensed as an audiologist by the State. In addition to required licensure, audiologists are encouraged to obtain a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA).

In addition to the above qualification criteria, the following requirements must also be met:

1. The testing is ordered by a physician to obtain additional information to evaluate the need for or appropriate type of medical or surgical treatment for a hearing deficit or a medical problem; and
2. The name of the physician ordering the testing is reported on the audiologist's claim. (For example, testing performed by the audiologist to measure a hearing deficit or to identify the factors responsible for the deficit are covered when such services enable the physician to determine whether otologic surgery is indicated).

Basic Audiometry: Adequate testing requires an audiometer (device for

presenting sounds to the patient at precisely controlled intensity), a sound-proof environment, a physician/audiologist, and a cooperative patient.

CPT code 92552 or 92553 will be covered by this A/B MAC if ordered and performed in conjunction with vestibular function testing. No other hearing tests will be covered by this A/B MAC when performed in conjunction with vestibular function testing, for the diagnosis of balance problems.

Coding Information

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Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

999x Not Applicable

Revenue Codes: [back to top](#)

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999 Not Applicable

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92540 BASIC VESTIBULAR EVALUATION, INCLUDES SPONTANEOUS NYSTAGMUS TEST WITH ECCENTRIC GAZE FIXATION NYSTAGMUS, WITH RECORDING, POSITIONAL NYSTAGMUS TEST, MINIMUM OF 4 POSITIONS, WITH RECORDING, OPTOKINETIC NYSTAGMUS TEST, BIDIRECTIONAL FOVEAL AND PERIPHERAL STIMULATION, WITH RECORDING, AND OSCILLATING TRACKING TEST, WITH RECORDING

92541 SPONTANEOUS NYSTAGMUS TEST, INCLUDING GAZE AND FIXATION NYSTAGMUS, WITH RECORDING

92542	POSITIONAL NYSTAGMUS TEST, MINIMUM OF 4 POSITIONS, WITH RECORDING
92543	CALORIC VESTIBULAR TEST, EACH IRRIGATION (BINAURAL, BITHERMAL STIMULATION CONSTITUTES 4 TESTS), WITH RECORDING
92544	OPTOKINETIC NYSTAGMUS TEST, BIDIRECTIONAL, FOVEAL OR PERIPHERAL STIMULATION, WITH RECORDING
92545	OSCILLATING TRACKING TEST, WITH RECORDING
92546	SINUSOIDAL VERTICAL AXIS ROTATIONAL TESTING
92547	USE OF VERTICAL ELECTRODES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
92548	COMPUTERIZED DYNAMIC POSTUROGRAPHY
92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY
92553	PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE

ICD-9 Codes that Support Medical Necessity [back to top](#)

The ICD-9-CM codes listed below are to their highest level of specificity. It is the provider's responsibility to avoid truncated codes by referring to the ICD-9-CM code book for the year in which the service was performed.

386.00 - 386.04	MÉNIÈRE'S DISEASE, UNSPECIFIED - INACTIVE MÉNIÈRE'S DISEASE
386.10 - 386.12	PERIPHERAL VERTIGO UNSPECIFIED - VESTIBULAR NEURONITIS
386.19	OTHER PERIPHERAL VERTIGO
386.2	VERTIGO OF CENTRAL ORIGIN
386.30 - 386.35	LABYRINTHITIS UNSPECIFIED - VIRAL LABYRINTHITIS
386.40 - 386.43	LABYRINTHINE FISTULA UNSPECIFIED - SEMICIRCULAR CANAL FISTULA
386.48	LABYRINTHINE FISTULA OF COMBINED SITES
386.50 - 386.56	LABYRINTHINE DYSFUNCTION UNSPECIFIED - LOSS OF LABYRINTHINE REACTIVITY BILATERAL
386.58	OTHER FORMS AND COMBINATIONS OF LABYRINTHINE DYSFUNCTION
386.8	OTHER DISORDERS OF LABYRINTH
386.9	UNSPECIFIED VERTIGINOUS SYNDROMES AND LABYRINTHINE DISORDERS
389.10*	SENSORINEURAL HEARING LOSS UNSPECIFIED
389.11*	SENSORY HEARING LOSS, BILATERAL
389.12*	NEURAL HEARING LOSS, BILATERAL
389.14*	CENTRAL HEARING LOSS

780.4 DIZZINESS AND GIDDINESS

Tests for the ICD-9 diagnosis codes indicated with an asterisk (*) are covered only for an initial evaluation of a balance problem.

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ICD-9 Codes that DO NOT Support Medical Necessity [back to top](#)

V53.2 FITTING AND ADJUSTMENT OF HEARING AID

V72.19 OTHER EXAMINATION OF EARS AND HEARING

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General Information

Documentation Requirements [back to top](#)

Supportive documentation evidencing the condition and treatment is expected to be documented in the medical record and be available upon request.

Appropriate ICD-9-CM codes must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.

The patient's record must document a balance problem which required further evaluation to determine the appropriate medical or surgical treatment.

When the billing provider is not the referring provider, this A/B MAC may request full contact information for the referring provider and request documentation from the referring provider. This documentation would include records of a full evaluation including clinical impression, written orders, and referral(s).

It is not enough to link the procedure code to a payable ICD-9-CM code. The diagnosis or clinical suspicion must be present for the procedure to be paid, and the patient's medical record must document that the coverage criteria in this policy have been met. Covered services must meet general community standards of appropriate medical care. For example, extremely mild symptoms of very short duration may not justify procedures or testing, even though a listed ICD-9-CM symptom might superficially be met. Inclusion of certain "not otherwise specified" codes does not mean that any other associated disorder is covered.

Services are excluded when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the physician, or the diagnostic services are performed only to determine the need for or the appropriate type of a hearing aid. Diagnostic services performed by a qualified audiologist and meeting the above requirements are payable as "other diagnostic tests". Medicare coverage for these services is determined by the reason the tests were performed, rather than the diagnosis or the patient's condition.

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It is very rarely necessary to conduct the entire battery of tests. In particular, as discussed in the Indications and Limitations section, previous workup, history, and exam will be carefully scrutinized to ensure that exhaustive test batteries are justified and appropriate to the patient's history and symptoms. It is not necessary to conduct additional tests once the problem and its diagnosis have been determined or identified.

Most of the tests for vestibular function are conducted once per day. Repeat testing is only covered when medically necessary to assess specific medical or surgical treatments. Medically necessary means, for example, if symptoms are unchanged or a treatment completely resolves symptoms, elaborate repeat testing is not usually medically necessary to confirm this.

Repeat testing on a regular basis, in the absence of the resumption of symptoms, is not warranted. A few conditions may require testing on multiple days due to variably acute symptoms such as benign positional vertigo which varies with inner ear canal stones. However, in this case, isolated testing with 92542 is usually sufficient, and within several episodes, a firm diagnosis should be ruled in or out.

Tests with video recording are coded the same as the equivalent standard test, unless new CPT codes are issued. Manufacturer's guidance to bill e.g. 92546, in multiple units does not override the CMS billing rules.

CPT code 92285, 92541, and 92542 are more likely to be medically necessary for follow up of disorders, likely secondary to canal block pathology. For this purpose, there may be testing at several visits, at intervals, for evaluation of interval change and symptoms.

SUMMARY:

CPT codes 92542, 92544, 92545, 92546, and 92548 are billable once per day, and repeated analysis or confirmation of findings within the session is considered part of one test. Note, for example, that CPT code 92542 specifically requires 4 or more positions tested in order to bill for one unit (Per CPT definition).

CPT code 92543 may often be billed up to a quantity of 4 units, of the test per session, when four different tests are performed, as described in the CPT text and in CPT Assistant, May 1996.

CPT code 92547 may be billed multiple times as required by other, medically necessary tests. Since the same electrodes are typically used for several serial tests, billing more than 6 per day would be atypical.

CPT codes 92531, 92532, 92533, and 92534 are considered bundled physical exam codes by CMS, have RVU's of zero, and are not payable.

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Other Contractor's Policies

Specialists in Neurology, Neurosurgery, Neuro-otolaryngology

www.umich.edu/oto/patient/clinicalsub/vestibular

www.vestibular.org/overview

www.ucsf.edu/audio/vestibular

www.depts.washington.edu/coursefo/vesttest

www.militaryaudiology.org/afaa/docs/13

Goebel JA. *Practical management of the dizzy patient*. Lippincott. 2001.

Desmond A. *Vestibular Function, Evaluation and Treatment* Thieme. 2004.

NOTE: Some of the websites used to create this policy may no longer be available.

Advisory Committee Meeting Notes [back to top](#)

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the affected provider community.

Contractor Advisory Committee meeting dates:

California -

Hawaii -

Nevada -

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Revision #5

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Revision #5 effective for dates of service on or after 01/01/2010
Revisions made: Annual 2010 CPT/HCPCS update, under Indications and Limitations of Coverage and/or Medical Necessity section of LCD and under subheading "The following CPT codes for Vestibular Function Testing are covered by this policy" added definition of 92540 and added the statement "This test should not be billed with CPT codes 92541, 92542, 92544 or 92545 as they are included in this test." Under CPT/HCPCS Codes section of LCD added CPT code 92540 and CPT code 92543 had a descriptor change.

Revision #4 effective for dates of service on or after 06/08/2009
Revision made: Under "CMS National Coverage Policy" added Change Request 1573 as a reference citation for Publication 100-02, Chapter 15, §§80.3 and 80.3.1. Corrected citation of Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3, §3.4.1.1.4 to §3.4.1.1.E. Under "Indications and Limitations of Coverage and/or Medical Necessity" added the sentence "We would expect this documentation to be in the chart if requested" to the section regarding dizziness ICD-9 code 780.4 may support the medical necessity for hearing tests. Under ICD-9 codes that support medical necessity added ICD-9 code 780.4.

Revision #3, 02/26/2009

This LCD is being revised to implement the streamlining of the Part B LCDs per the published article "Palmetto Team to Streamline Part B LCDs in Jurisdiction 1 (J1)." This article can be viewed at www.PalmettoGBA.com by searching for the above article name. This revision will become effective on 02/26/2009.

Revision #2, 10/1/2008

This LCD is being revised due to the annual FY 2009 ICD-9 CM code update. Under ICD-9 Codes That Support Medical Necessity the following codes were revised: 386.00, 386.01, 386.03, and 306.04. Under Indications and Limitation of Coverage removed duplicate Federal Regulations and CMS Manual citations. Under Documentation Requirements removed duplicate SSA and CMS Manual citations. Under Sources of Information and Basis for Decision section references were placed in the AMA citation format. This revision will become effective 10/01/2008.

Revision #1, 09/02/2008

This LCD is being revised to add Bill Type 999X because the automated system transcription process was incomplete.

08/10/2008 - This policy was updated by the ICD-9 2008-2009 Annual Update.

11/15/2009 - The description for CPT/HCPCS code 92543 was changed in group 1

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05/12/2009

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Updated on 12/11/2009 with effective dates 01/01/2010 - N/A

[Updated on 11/15/2009 with effective dates 06/08/2009 - 12/31/2009](#)

[Updated on 05/14/2009 with effective dates 06/08/2009 - N/A](#)

[Updated on 02/19/2009 with effective dates 02/26/2009 - 06/07/2009](#)

[Updated on 09/11/2008 with effective dates 10/01/2008 - 02/25/2009](#)

[Updated on 08/10/2008 with effective dates 09/02/2008 - 09/30/2008](#)

[Updated on 07/26/2008 with effective dates 09/02/2008 - N/A](#)

[Updated on 06/08/2008 with effective dates 09/02/2008 - N/A](#)

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