

<b>2.01.02 Dynamic Posturography</b>	
<b>Original Policy Date:</b> July 1, 2011	<b>Effective Date:</b> April 1, 2024
<b>Section:</b> 2.0 Medicine	<b>Page:</b> Page 1 of 10

**Policy Statement**

I. Dynamic posturography is considered **investigational**.

**NOTE:** Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

**Policy Guidelines**

The following CPT code is specific to computerized dynamic posturography:

- **92548:** Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report

There is a CPT to add clarity to code 92548 and represents an add-on code for reporting motor control testing and adaption:

- **92549:** Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)

**Description**

Dynamic posturography tests a patient’s balance control in situations intended to isolate factors that affect balance in everyday experiences. Posturography provides quantitative information on the degree of imbalance present but is not intended to diagnosis specific types of balance disorders.

**Related Policies**

- N/A

**Benefit Application**

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

**Regulatory Status**

In 1985, the NeuroCom EquiTest® (NeuroCom International, Portland, OR; now Clackamas, OR), a dynamic posturography device, was cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. Other dynamic posturography device makers include Vestibular

Technologies (Cheyenne, WY) and Medicauteurs (Balma, France). Companies that previously manufactured dynamic posturography devices include Metitur (Jyvaskyla, Finland) and Micromedical Technology (Chatham, IL). FDA product code: LXV.

## Rationale

### Background

#### Balance Disorders

Complaints of imbalance are common in older adults and contribute to the risk of falling in this population. Falls are an important cause of death and disability in this population in the United States. Maintenance of balance is a complex physiologic process, requiring the interaction of the vestibular, visual, and proprioceptive/somatosensory system, and central reflex mechanisms. Balance is also influenced by the general health of the patient (i.e., muscle tone, strength, range of motion). Therefore, identifying and treating the underlying balance disorder can be difficult. Commonly used balance function tests (e.g., electronystagmography, rotational chair tests) attempt to measure the extent and site of a vestibular lesion but do not assess the functional ability to maintain balance.

#### Role in Diagnosis

Dynamic posturography aims to provide quantitative information on a patient's functional ability to maintain balance. The patient, wearing a harness to prevent falls, stands on an enclosed platform surrounded by a visual field. By altering the angle of the platform or shifting the visual field, the test assesses movement coordination and the sensory organization of visual, somatosensory, and vestibular information relevant to postural control. The patient undergoes 6 different testing situations designed to evaluate the vestibular, visual, and proprioceptive/somatosensory components of balance. In general terms, the test measures an individual's balance (as measured by a force platform to calculate the movement of the patient's center of mass) while visual and somatosensory cues are altered. These tests vary by whether eyes are open or closed, the platform is fixed or sway-referenced, and whether the visual surround is fixed or sway-referenced. Sway-referencing involves making instantaneous computer-aided alterations to the platform or visual surround to coincide with changes in body position produced by sway. The purpose of sway-referencing is to cancel out accurate feedback from somatosensory or visual systems that are normally involved in maintaining balance. In the first 3 components of the test, the support surface is stable, and visual cues are either present, absent, or sway-referenced. In tests 4 to 6, the support surface is sway-referenced to the individual, and visual cues are either present, absent, or sway-referenced. In tests 5 and 6, the only accurate sensory cues available for balance are vestibular cues. Results of computerized dynamic posturography have been used to determine what type of information (i.e., visual, vestibular, proprioceptive) can and cannot be used to maintain balance. Dynamic posturography cannot be used to localize the site of a lesion.

Posturography tests a patient's balance control in situations intended to isolate factors that affect balance in everyday experiences. Balance can be rapidly assessed qualitatively by asking the patient to maintain a steady stance on a flat or compressible surface (i.e., foam pads) with the eyes open or closed. By closing the eyes, the visual input into balance is eliminated. Use of foam pads eliminates the sensory and proprioceptive cues. Therefore, the only vestibular input is available when standing on a foam pad with eyes closed.

### Literature Review

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

This review was informed by a 1996 TEC Assessment, which concluded that the evidence was insufficient to determine whether dynamic posturography distinguished between peripheral and central vestibular dysfunction.<sup>1</sup>

### **Dynamic Posturography Clinical Context and Test Purpose**

The purpose of dynamic posturography in individuals who have balance dysfunction is to inform a decision whether to pursue additional diagnostic workup (e.g., imaging studies that would not have been indicated based on clinical presentation alone) or immediate treatment.

#### ***Population***

The relevant population of interest is individuals presenting with balance dysfunction or dizziness. It would be expected that these individuals will have had an initial basic evaluation directed by symptoms that will have included a clinical examination and history, with appropriate vital signs and orthostatic blood pressure measurements, and may have had basic evaluations as directed by their symptoms (e.g., electrocardiogram).

#### ***Interventions***

The intervention includes a class of dynamic posturography tests. A number of tests have clearance from the U.S. Food and Drug Administration. The specific maneuvers may be operator dependent.

#### ***Comparators***

Depending on the clinical presentation, individuals with balance dysfunction may be managed with clinical evaluation alone or with more intensive evaluations including vestibular function testing, which can be used to localize the cause of the dysfunction.

#### ***Outcomes***

The outcomes of interest are to diagnose and treat the underlying condition correctly. The time frame of interest is months to approximately a year.

### **Study Selection Criteria**

For the evaluation of clinical validity of dynamic posturography, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores);
- Included a suitable reference standard;
- Patient/sample clinical characteristics were described;
- Patient/sample selection criteria were described.

### Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

### Review of Evidence

We did not identify any studies that evaluated the sensitivity and specificity of dynamic posturography for diagnosing any specific balance disorder compared with commonly accepted balance tests. There is no criterion standard test for measuring balance, which is a physiologic parameter. Absent a criterion standard comparison; the literature search sought to identify studies that systematically compared results of dynamic posturography and other balance tests in an appropriate patient population (ie, individuals at increased risk of falling due to balance issues). Several studies have used both dynamic posturography and another test to assess balance. For example, Fritz et al (2015) assessed the correlation between dynamic and static posturography and other measures of gait and balance dysfunction in 57 ambulatory patients with multiple sclerosis.<sup>2</sup> Two dynamic posturography parameters and 4 static posturography parameters were measured. Walking velocity (the alternative test) was measured in 2 ways: (1) in a laboratory using the Optotrak Motion Capture System and (2) using the timed 25-foot walk test. In regression analysis, demographics, one of the dynamic posturography parameters (anteroposterior sway), and one of the static posturography parameters (eyes open, feet apart) explained 95.3% of the variance in walking velocity. A higher degree of anteroposterior sway, assessed using dynamic posturography, was significantly associated with higher walking velocity. Although the study found that dynamic posturography was associated with measures of walking velocity, the utility of this information regarding impact on patient management is uncertain.

A study by Ferrazzoli et al (2015) compared dynamic posturography with the Berg Balance Scale score.<sup>3</sup> The Berg Balance Scale is a 14-item tool that assesses performance on a variety of functional tasks, each rated 0-to-4 (maximal score, 56 points). Lower scores indicate higher fall risk. The study included 29 patients with Parkinson disease (PD) not complaining of balance problems and 12 healthy controls matched for age and sex. Scores on the Berg Balance Scale were significantly lower in PD patients than in controls ( $p=.002$ ). Similarly, results of body sway analysis assessed by posturography differed significantly between PD patients and controls. Specifically, compared with controls, PD patients had a higher standard deviation of body sway measurements in the eyes open ( $p=.005$ ) and in the eyes open counting ( $p=.020$ ) conditions. The standard deviation of PD patients was also higher than controls in posturography along the mediolateral axis in the eyes open condition ( $p=.019$ ), but results were similar in the eyes open counting condition. The authors suggested that posturography could be used to identify early balance disorders in PD patients before they develop clinical symptoms, and that rehabilitation programs could be developed to address specific balance issues. As discussed in the next section, there is a lack of prospective studies comparing health outcomes in patients managed with and without dynamic posturography. Other published literature on dynamic posturography has assessed fall risk in older individuals and other populations.<sup>4,5,6,7</sup> For example, Whitney et al (2006) retrospectively reviewed 100 charts of individuals referred to a balance and falls clinic with a vestibular diagnosis using dynamic posturography.<sup>7</sup> Patients who reported multiple falls over 6 months had lower initial scores on the Sensory Organization Test than those who reported 1 or no falls.

Additional studies have used dynamic posturography as a research tool to study balance (e.g., in older adults, PD patients, knee osteoarthritis patients); these studies were not designed to evaluate the clinical validity of dynamic posturography.<sup>8,9,10,11,12</sup> Dynamic posturography has also been considered a control technique in studies evaluating other novel methods of assessing balance. For example, Alahmari et al (2014) assessed the reliability and validity of a balance rehabilitation device and compared findings with dynamic posturography using the EquiTest.<sup>13</sup>

**Clinically Useful**

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials (RCTs).

No randomized or nonrandomized controlled studies were identified that compared health outcomes in patients when treatment decisions were made with and without the results of dynamic posturography. A 2009 RCT was identified, but it used dynamic posturography as an outcome measure, rather than as a tool for making treatment decisions; thus conclusions cannot be drawn from it on the impact of posturography on patient management.<sup>14</sup>

Several retrospective studies have described a customized exercise program based on results of a complete medical and neuro-otologic history and physical examination that included platform posturography.<sup>15,16</sup> However, the contribution of dynamic posturography to the overall assessment and customization of the exercise program by the Badke group is unclear. In particular, the reports did not describe how (or whether) the exercise programs were modified based on specific deficits identified by platform posturography. Customized vestibular rehabilitation programs can be devised with a standard battery of tests.<sup>17</sup> These retrospective reports were also limited by selection bias and lack of follow-up. Moreover, while these studies showed that individualized therapy could improve patient outcomes, no controlled trials have assessed whether individually customized therapy programs are more effective than generic vestibular exercises.

Also, other related studies have included the use of posturography in the assessment of patients after clinical intervention. Examples included studies conducted with individuals with PD<sup>18,19</sup>, and assessment of patients with idiopathic normal pressure hydrocephalus before and after shunt surgery.<sup>20</sup> For instance, Nocera et al (2009) used posturography to evaluate the effectiveness of a home-based exercise program on postural control for 10 patients with PD.<sup>19</sup> The 10 patients and 10 healthy age-matched controls were assessed with dynamic posturography before and after the 10-week intervention. Dynamic posturography was not used to select patients for the intervention or to individualize the intervention.

**Chain of Evidence**

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

**Section Summary: Dynamic Posturography**

Describing the diagnostic performance of dynamic posturography in terms of sensitivity and specificity is difficult given the lack of a true criterion standard for measuring balance. The available studies comparing dynamic posturography with other types of clinical measures of balance have suggested that posturography results correlate with those measures; however, whether dynamic posturography can be used as a diagnostic test is unknown. Direct evidence of how dynamic posturography can be used to improve outcomes is lacking. In the absence of direct evidence for a diagnostic test, a chain of evidence can sometimes be identified to demonstrate improvement in health outcomes. However, in the case of dynamic posturography, the chain of evidence about clinical validity and how the test would be used in practice is uncertain; therefore, no inferences can be made about clinical utility.

### Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

### Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

### The American Academy of Otolaryngology-Head and Neck Surgery

In a position statement adopted in 2007 and revised in 2014, the American Academy of Otolaryngology-Head and Neck Surgery recognized computerized dynamic platform posturography and dynamic (or moving) platform posturography as medically indicated and appropriate tools in the evaluation or therapy of certain persons with suspected balance or dizziness disorders.<sup>21</sup> In 2017, updated guidelines on the management of benign paroxysmal positional vertigo were published; posturography is not mentioned.<sup>22</sup>

### U.S. Preventive Services Task Force Recommendations

Not applicable.

### Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

### Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in December 2023 did not identify any ongoing or unpublished trials that would likely influence this review.

## References

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## Documentation for Clinical Review

- No records required

## Coding

*This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.*

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	92548	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report
	92549	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)
HCPCS	None	

## Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
07/01/2011	BCBSA Medical Policy adoption
07/31/2015	Coding update
10/30/2015	Policy revision without position change
04/01/2016	Policy revision without position change
04/01/2017	Policy revision without position change
04/01/2018	Policy revision without position change
04/01/2019	Policy revision without position change
03/01/2020	Coding update
05/01/2020	Annual review. No change to policy statement. Literature review updated.
04/01/2021	Annual review. No change to policy statement. Literature review updated.
04/01/2022	Annual review. No change to policy statement. Policy guidelines and literature review updated.
04/01/2023	Annual review. No change to policy statement. Literature review updated.
04/01/2024	Annual review. No change to policy statement. Literature review updated.

## Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.



**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: [MedPolicy@blueshieldca.com](mailto:MedPolicy@blueshieldca.com)

*Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.*

**Appendix A**

<b>POLICY STATEMENT</b> <b>(No changes)</b>	
<b>BEFORE</b>	<b>AFTER</b>
<b>Dynamic Posturography 2.01.02</b>  <b>Policy Statement:</b> I. Dynamic posturography is considered <b>investigational</b> .	<b>Dynamic Posturography 2.01.02</b>  <b>Policy Statement:</b> I. Dynamic posturography is considered <b>investigational</b> .