AMERICAN ACADEMY OF OTOLARYNGOLOGY– HEAD AND NECK SURGERY

Clinical Indicators: Canalith Repositioning Procedures (CRPs)

(Otolith Repositioning; Epley Maneuver; Semont Maneuver, Lateral canal repositioning maneuvers)

Procedure

	CPT	Days[1]
Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day	95992	XXX

Indications

1. History (one or more required)

a) Description of paroxysmal vertigo or unsteadiness

b) Vertigo, typically lasting less than a minute, usually associated with lying down, sitting up, turning side to side in bed, or any significant movement of the head and neck.

c) Functional impairment due to vertigo

d) History of head trauma (especially in younger aged individuals where idiopathic Benign Paroxysmal Positional Vertigo (BPPV) is less common)

e) History of Meniere's disease

f) History of vestibular neuritis

g) No evidence of neck or back disorders that might contraindicate this maneuver

2. Procedure

a) Neurotologic examination:
- Otoscopy and complete otolaryngologic exam
- Spontaneous or gaze nystagmus
- Cranial nerve testing
- Dix-Hallpike maneuver
  - With or without Frenzel lenses or video goggles
  - Sidelying maneuver (lateral canal BPPV)

b) Positional Testing (with or without Frenzel lenses or video goggles) if Dix-Hallpike maneuver negative

3. Tests (optional)
- Audiometry
- Electro- or videonystagmography (ENG/VNG)
- Vestibular Evoked Myogenic Potentials (VEMP)

[1] RBRVS Global Days

- MRI or other site of lesion testing (eg, Otoacoustic emissions, Auditory Brainstem Audiometry), if persistent symptoms
- If sudden hearing loss is associated[2]

4. Treatment

- Various Canalith Repositioning Procedures (i.e., Epley, Semont, Lateral Canal, etc.) depending on examination findings.
- Vestibular exercises (for milder symptoms with no findings on examination) or Vestibular Rehabilitation in select patients.

Outcome Review

1) One-two weeks.

a) Presence or absence of positional vertigo

2) Beyond One Month

a) Recurrence or persistence of positional vertigo

b) Resumption of normal life style

c) Consideration for further evaluation if symptoms persist or other neurological findings.

Associated ICD-9 Diagnostic Codes (Representative, but not all-inclusive, codes)

780.4 Dizziness and giddiness
386.11 Benign paroxysmal vertigo

Patient Information

Benign paroxysmal positional vertigo is one of the most common causes of vertigo. This inner ear problem is caused by calcium carbonate crystals ("otoliths") floating in the fluid of the inner ear. On position change, these crystals stimulate part of the inner ear and produce short periods of dizziness. Causes for the crystals to break away are head injuries, degenerative diseases, viral infections of the inner ear or auditory-vestibular nerve (vestibular neuritis), or are unknown. In time, these crystals may settle and symptoms resolve. It is common for symptoms to recur if the condition has never been treated.

Diagnosis is made by targeted history and physical examination which includes the Dix-Hallpike maneuver and observation of classic BPPV findings. The crystals can then be repositioned to get rid of the vertigo. This repositioning maneuver is called the Canalith Repositioning Procedure (CRP). There are various types of CRPs such as the Epley maneuver, Semont maneuver, and others. This is an in-office therapy that takes about 30 minutes. The patient is placed in several different positions during the examination and maneuver which usually causes temporary

[2] see AAO-HNS Clinical Practice Guideline on Sudden Hearing Loss

dizziness. Patients may wear a soft neck collar to help keep the head and neck in position afterwards; patients are given detailed post-procedure instructions regarding head positioning. Most patients have improvement or resolution of symptoms with one treatment. Some patients will require more than one or two CRP treatments, and some may need vestibular rehabilitation.

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