# MEDICAL POLICY

| POLICY TITLE | DYNAMIC POSTUROGRAPHY |
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| POLICY NUMBER | MP 2.011 |

| CLINICAL BENEFIT | ☒ MINIMIZE SAFETY RISK OR CONCERN.<br>☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS.<br>☐ ASSURE APPROPRIATE LEVEL OF CARE.<br>☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS.<br>☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET.<br>☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE. |
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| **Effective Date:** | **8/1/2025** |



## I. POLICY

Dynamic posturography is considered **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

## II. PRODUCT VARIATIONS TOP

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

**FEP PPO**: Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

## III. DESCRIPTION/BACKGROUND TOP

### 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.

### 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 through the 510(k) process. Other dynamic posturography device makers include Vestibular Technologies (Cheyenne, WY) and Medicapteurs (Balma, France). Companies that previously manufactured dynamic posturography devices include Metitur (Jyvaskyla, Finland) and Micromedical Technology (Chatham, IL). Food and Drug Administration product code: LXV.

## IV. RATIONALE

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### Summary of Evidence

For individuals with suspected balance disorders who receive dynamic posturography, the evidence includes cross-sectional comparisons of results in patients with balance disorders and healthy controls and retrospective case series reporting outcomes for patients assessed with dynamic posturography as part of clinical care. Relevant outcomes are test accuracy and validity, symptoms, and morbid events. There are no generally accepted reference standards for dynamic posturography, which makes it difficult to determine how testing results can be applied to clinical care. There are no studies demonstrating the clinical utility of the test that would lead

to changes in management that improve outcomes (e.g., symptoms, function). The evidence is insufficient to determine the effects of the technology on health outcomes.

## V. DEFINITIONS

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**NA**

## VII. DISCLAIMER

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*Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as required by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These polices are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.*

## VIII. CODING INFORMATION

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**Note:** This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

**Investigational; therefore, not covered**

| Procedure Codes | | | | | | | | |
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| 92548 | 92549 | | | | | | | |

## IX. REFERENCES

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## X. POLICY HISTORY

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| **MP 2.011** | **01/01/2020 Administrative Update.** Coding updated. Added new code 92549. |
| | **03/23/2020 Consensus Review.** Coding reviewed. Policy statement unchanged. References updated. Product variations updated. |
| | **04/15/2021 Consensus Review.** No changes to coding. References updated. |
| | **03/07/2022 Consensus Review.** No changes to coding. |
| | **01/03/2023 Consensus Review.** Policy statement unchanged. References reviewed and updated. |
| | **05/22/2023 Consensus Review.** Policy statement unchanged. References reviewed and updated. |
| | **05/03/2024 Consensus Review.** Policy statement unchanged. References reviewed and updated. No coding changes. |
| | **04/01/2025 Consensus Review.** Policy statement unchanged. References reviewed. No coding changes |

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