healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Canalith Repositioning Procedure		
Policy Number:	PO-RE-127v1		
Effective Date:	5/1/2025	**Last Approval Date:**	2/24/2025

I. Policy Description

Healthfirst adheres to the Centers for Medicare & Medicaid Services (CMS) guidelines for Canalith Repositioning Procedures. This policy outlines the reimbursement criteria and procedure for the CPT code 95992, which is designated for the therapeutic management of benign paroxysmal positional vertigo (BPPV). The policy aims to ensure appropriate utilization and reimbursement for this procedure based on reimbursement guidelines and specific diagnosis codes below.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)
- Essential Plan (EP)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Medicare PPO
- Qualified Health Plan (QHP)

Reimbursement Guidelines:

1. Medicare Advantage, Medicare PPO and Medicaid Advantage Plus/MAP (CompleteCare)

a. Claims must be billed in accordance with CMS guidelines which states
b. CPT code 95992, describing canalith repositioning procedure(s), may be reported with no more than one unit of service per day. This includes all necessary services to achieve the canalith repositioning.
c. Other CPT codes (e.g., 97110, 97112, 97140, 97530) shall not be reported separately for services related to the canalith repositioning.
d. The procedure will only be reimbursed when billed with one or more of the following diagnosis codes:

ICD 10 Code	ICD 10 Code Description
H81.11	Benign paroxysmal vertigo, right ear

H81.12	Benign paroxysmal vertigo, left ear
H81.13	Benign paroxysmal vertigo, bilateral

e. Providers must ensure that all claims are supported by appropriate clinical documentation justifying the medical necessity of the Canalith Repositioning Procedure in alignment with the approved diagnosis codes.

f. CPT 95992 will be denied when billed without a BPPV diagnosis.

2. Child Health Plus (CHP), Essential Plan (EP), Medicaid Managed Care (MMC), PWP/HARP and Qualified Health Plan (QHP)

a. The billing restrictions in section one does not apply to these lines of business.

Adjudication and Appeal Process

- Reimbursement for Canalith Repositioning Procedure will be determined based on the provider's scope and the reimbursement rates outlined in the provider's contract with Healthfirst.
- Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.
- Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

II. Applicable Codes

Code	Description	Comment
95992	Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day	Once per day

III. Definitions

Term	Meaning
CPT	Current Procedural Terminology
BPPV	Benign Paroxysmal Positional Vertigo

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Medicare NCCI 2023 Coding Policy Manual – Chapter 11

VI. Revision History

Revision Date	Summary of Changes

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Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.