

# ***Practice Considerations When Triaging Patients With Hearing and Balance Symptoms***

**Carlos R. Esquivel, M.D., F.A.C.S., F.A.A.O.A.**

**Tara Zaugg, Au.D., C.C.C.-A.**

**Karen Lambert, P.T., D.P.T., N.C.S.**

**June 24 2021**

**1015-1145 ET**





# Presenters



**Carlos R. Esquivel, M.D., F.A.C.S., F.A.A.O.A.**

Acting Division Chief, Chief Medical Officer,  
Hearing Center of Excellence (HCE)  
Otolaryngologist (ENT)/Neurotology  
Lackland Air Force Base  
San Antonio

**Tara Zaugg, Au.D., C.C.C.-A.**

National Center for Rehabilitative Auditory Research  
VA Portland Health Care System  
Portland, Ore.

**Karen Lambert, P.T., D.P.T., N.C.S.**

Vestibular Program Manager  
Contractor, zCore Business Solutions  
Clinical Care Directorate, HCE, DHA  
Falls Church, Va.



# Carlos Esquivel, M.D., F.A.C.S., F.A.A.O.A.



Dr. Carlos Esquivel currently serves as the Hearing Center of Excellence (HCE) Division Chief. He also serves as a board certified Neurotologist and is a Principal Investigator for many research projects.

Prior to working for the HCE, Dr. Esquivel served more than 20 years in the military. He graduated from the University of Texas Medical Branch at Galveston, completed an internship in the U.S. Army and went on to be a flight surgeon at Hunter Army Airfield for two years. He completed a residency in Otolaryngology at Brooke Army Medical Center and a fellowship in Neurotology at Northwestern University in Chicago. He has served the last five years in the U.S. Air Force at Wilford Hall Ambulatory Surgical Center. Dr. Esquivel is board certified in General Otolaryngology and Neurotolgy. He holds fellowship status in the American Academy of Otolaryngic Allergy. He has written numerous peer-reviewed articles and several book chapters in the Otolaryngology field.



# Tara Zaugg, Au.D., C.C.C.-A.

Dr. Tara Zaugg is a certified, licensed, and clinically privileged research audiologist employed at the National Center for Rehabilitative Auditory Research (NCRAR) located at the Department of Veterans Affairs (VA) Portland Health Care System. Through involvement in tinnitus clinical trials over the last 21 years at the NCRAR, she has acquired experience with a wide range of tinnitus assessment and management methods. She also has experience training audiologists to implement various methods of tinnitus management. Dr. Zaugg is a co-developer of Progressive Tinnitus Management (PTM), which is endorsed by the Department of Veterans Affairs (VA) Central Office as the standard method of tinnitus management for VA hospitals. Dr. Zaugg strives to understand the perspective of clinicians and patients using PTM, and to incorporate their needs and insights into PTM as it evolves.





# Karen Lambert, P.T., D.P.T., N.C.S.



Karen H. Lambert, P.T., D.P.T., N.C.S. currently serves as the Vestibular Program Manager for the Hearing Center of Excellence (HCE) for the Department of Defense (DoD) and Veterans Administration (VA). In addition, she provides clinical care at a private outpatient physical therapy clinic specializing in treatment of patients with neurologic dysfunction. She earned a Master of Physical Therapy from Medical College of Pennsylvania (MCP) Hahnemann University in 2000 and her Doctorate of Physical Therapy from Drexel University in 2014. She received Board Certification in the area of Neurologic Physical Therapy from the American Physical Therapy Board of Clinical Specialties in 2006 and recertification in 2016. She has served on multiple task forces related to concussion and vestibular dysfunction for the Academy of Neurology within the American Physical Therapy Association. She served as the Officer in Charge of the Traumatic Brain Injury Section of Physical Therapy at Walter Reed Army Medical Center from December 2007-August 2010 where she participated in several research projects aimed at investigating the most effective rehabilitative techniques for service members with complaints of dizziness and/or cognitive impairment post mild to moderate traumatic brain injury.



# Disclosures

- Dr. Esquivel, Dr. Zaugg and Dr. Lambert have no relevant financial or non-financial relationships to disclose relating to the content of this activity; or presenter(s) must disclose the type of affiliation/financial interest (e.g. employee, speaker, consultant, principal investigator, grant recipient) with company name(s) included.
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# Learning Objectives

At the end of this presentation participants will be able to:

1. Discuss Clinical Practice Guidelines related to Sudden Sensorineural Hearing Loss (SSNHL).
2. Describe implications of the Hearing Center of Excellence's (HCE) clinical study related to SSNHL.
3. Define SSNHL and recognize the clinical presentation of SSNHL.
4. Select appropriate referrals for a patient who reports tinnitus.
5. Identify the location of the International Classification of Diseases-10 (ICD-10) Coding guidance for vestibular disorders on the HCE website to use as a resource.
6. Summarize the purpose of the Vestibular Disorders ICD-10 Coding Guidance document.
7. Execute appropriate treatment and referral for patients with SSNHL, tinnitus and vestibular disorders.



# Practice Considerations When Triaging Patients With Hearing and Balance Symptoms

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# Quality of Care

- The Institute for Healthcare Improvement (IHI) has proposed initiative known as the “Triple Aim” that will facilitate new designs in US healthcare systems. There are three interrelated factors:
  - Improving the patient experience of care.
  - Improving the health of populations.
  - Reducing the per capita cost of healthcare.
- $\text{Value} = \text{Quality} / \text{Cost}$ . Value of care increases when:
  - The quality of that care increases,
  - The cost of care declines, or
  - Some combination of these two outcomes occurs



# Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are developed throughout the world to reduce variation in practice and improve the quality of health care.

- There has been a shift from professional consensus to scientific rigor, employing systematic reviews and meta-analyses as the basis for developing guidelines.
- The Institute of Medicine (IOM) defines clinical practice guidelines as “a statement that includes recommendations intended to optimize patient care that are informed by systematic review of evidence and as assessment of the benefits and harms of alternative care options.”

(Turner, 2008)

(Wolff, 1999)



# Clinical Practice Guidelines

- Guidelines benefit patients through better outcomes, fewer ineffective interventions, greater consistency of care, and by creating secondary implementation materials (educational handouts).
- Clinicians can use guidelines to make better decisions, initiate quality improvement efforts, and prioritize new research initiatives.
- A flawed guideline could significantly harm both patients and clinicians, thereby mandating sound methodology as a basis for guideline development.

(Qaseem et al. 2012)  
(Wolff, 1999)

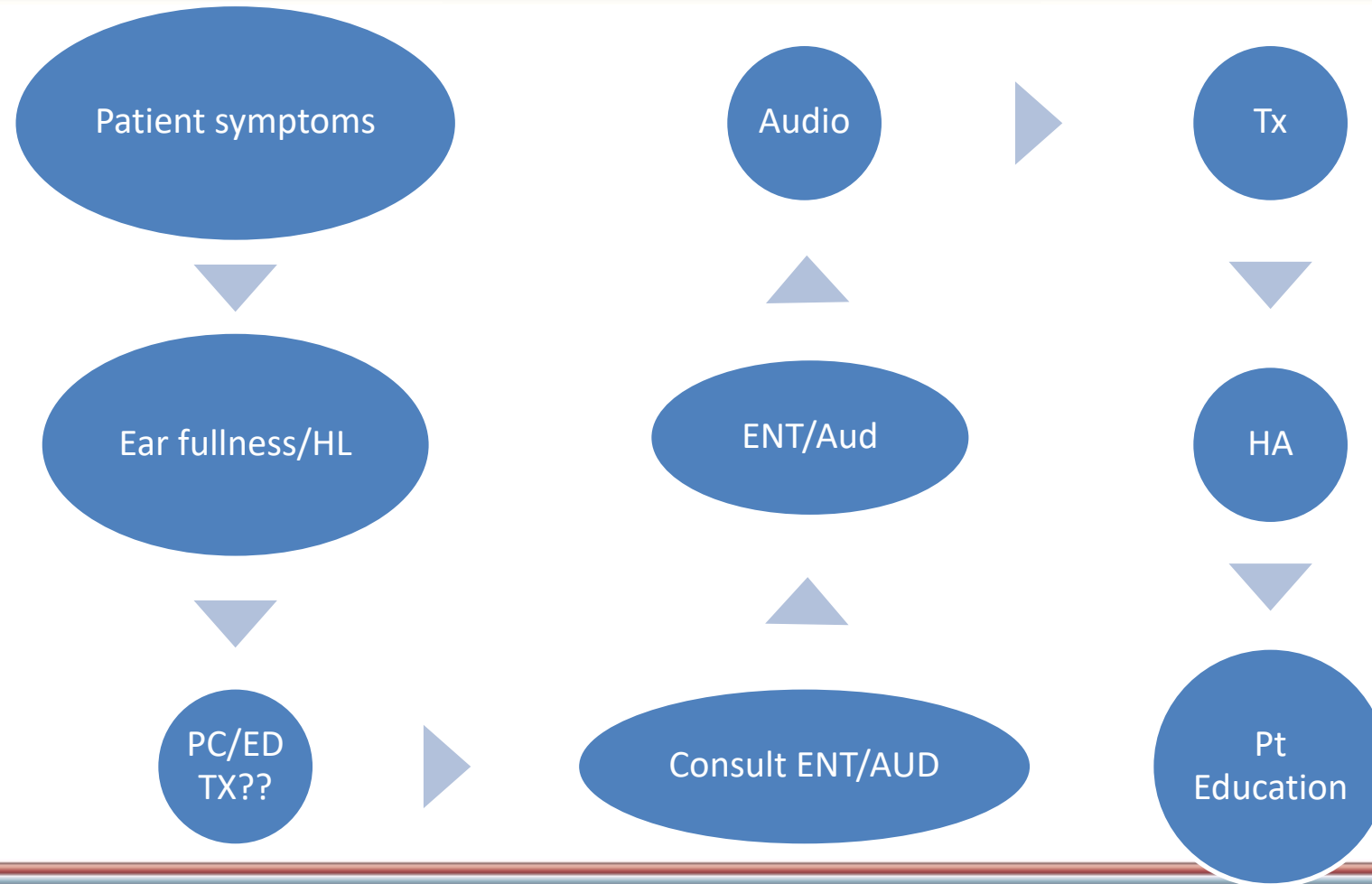


# Clinical Practice Guidelines

- Guidelines are NOT:
  - Reimbursement policies
  - Performance measures
  - Legal precedents
  - Measures of certification or licensing
  - Intended for comprehensive management
  - For provider selection or public reporting
  - Recipes for cookbook medicine



# Care Path SSNHL



\*Tx – treatment  
HL – Hearing Loss  
ENT – Otolaryngologist  
Aud – Audiologist  
HA – Hearing aid  
PC – Primary Care  
ED – Emergency Department



# Sudden Sensorineural Hearing Loss

- Sudden Sensorineural hearing loss (SSNHL) is defined as sudden hearing loss with no identifiable cause despite adequate investigation.
- American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) CPG- 30 dB or greater SNHL over at least three consecutive frequencies
- Hearing loss is related to the opposite ear's thresholds or previous audiogram, if available.
- Rapid onset over a 72 hour period.
- Difficult for health care providers to diagnose and treat.

(Stachler et al. 2012)



# Sudden Sensorineural Hearing Loss

- Incidence 5-20 per 100,000
- 4,000 cases per year in the U.S.
- Highest among 50-60 year olds
- M=F
- 2% Bilateral
- 90%+ are idiopathic



# Sudden Sensorineural Hearing Loss

- Viral infections
- Autoimmune
- Vascular Compromise



# Sudden Sensorineural Hearing Loss

## History and Physical

- SSNHL is considered to be a true otologic emergency, given the observation that there is less recovery of hearing when there is delay in treatment.
- The primary goal is to rule out any treatable causes.
- The otologic exam is **NORMAL**.



# Clinical Presentation of SSNHL

- Tinnitus occurs in 80%
- Vertigo, associated peripheral vestibular dysfunction in 30%
- About one third noticed hearing loss upon first awakening
- 80% report a feeling of ear **FULLNESS**



# Sudden Sensorineural Hearing Loss

## History and Physical

- Time course i.e. – When did this start? Days or months?
- Associated Symptoms:
  - Vertigo/dizziness
  - Aural Fullness (cerumen)/Eustachian tube dysfunction (ETD)
  - Tinnitus
- Ototoxic drug use
- Symptoms of a viral infection
- History of – trauma, noise exposure, straining, sneezing, head trauma
- Ask about recent air travel or water sports



# Sudden Sensorineural Hearing Loss

## History and Physical

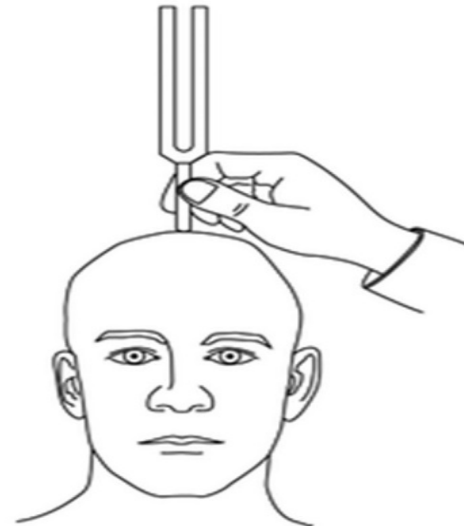


Source: Dr. Carlos Esquivel



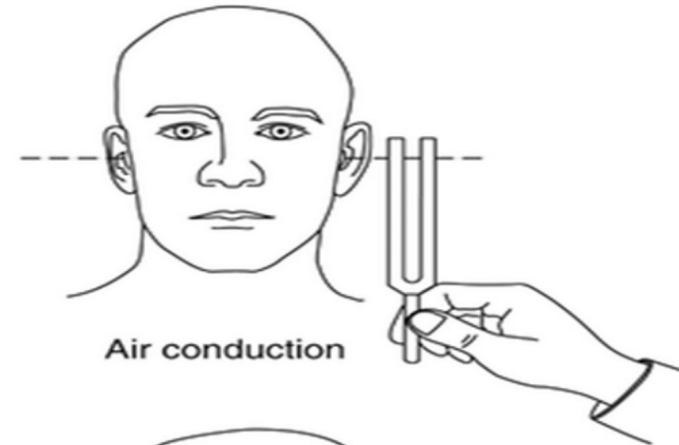
# Sudden Sensorineural Hearing Loss History and Physical

WEBER TEST

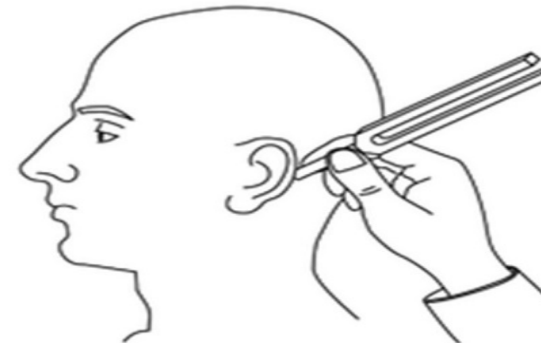


"Where do you hear the sound?"

RINNE TEST



Air conduction



Bone conduction

(McGee, 2007)



# PHYSICAL EXAM

## WEBER

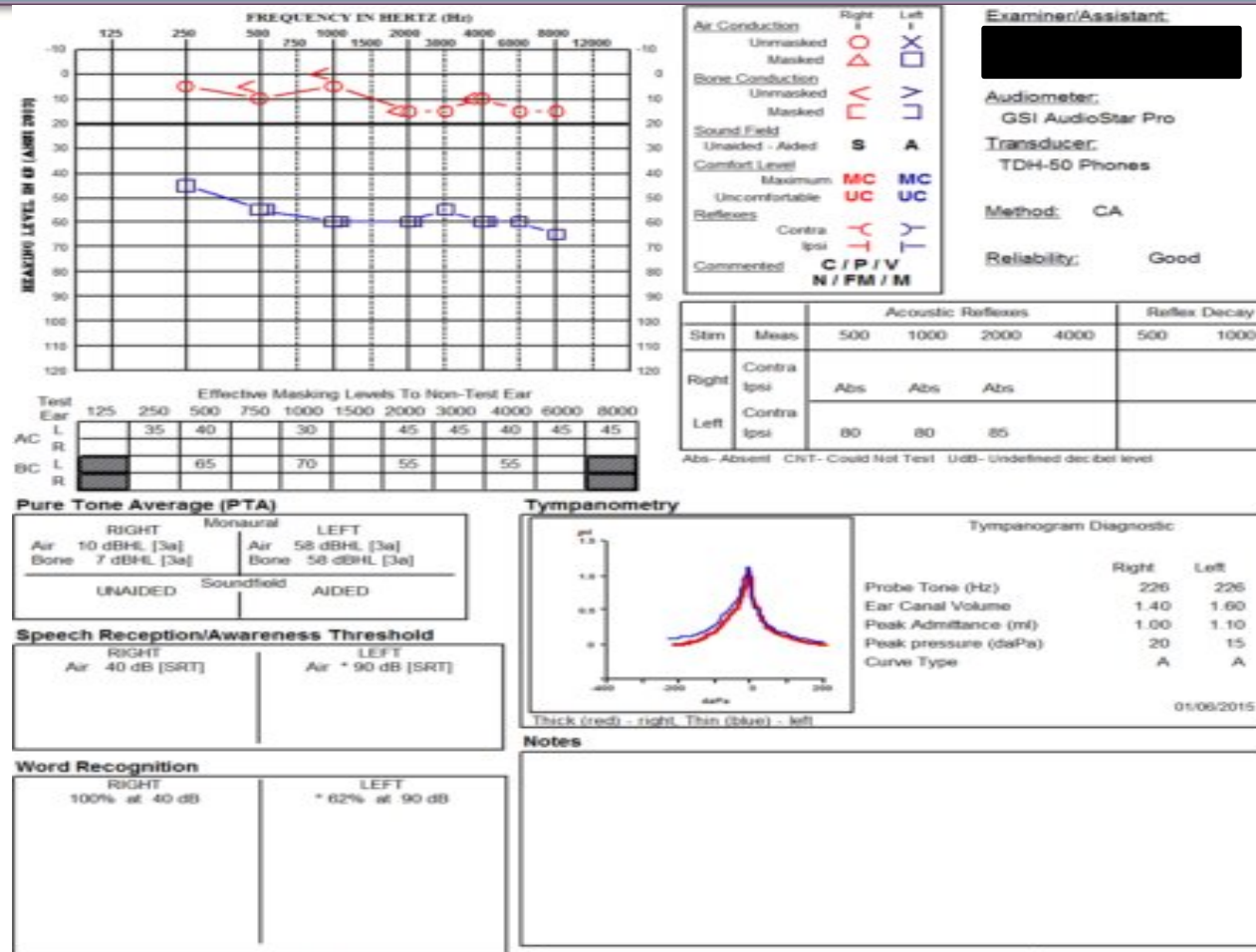
- Vibrating tuning midline
- Ask where the sound is heard, normal
- If lateralized to one :  
Conductive hearing loss (CHL) to that ear or SNHL in the opposite

## Rinne

- Vibrating tuning fork to mastoid area, move to the area of external auditory canal (EAC)
- Sound should be heard better at the EAC
- If sound is heard better at mastoid area= CHL



# Audiometric Test





# AAO-HNS Guideline Summary Statements

## Diagnosis

- Exclusion of CHL
- CT: Strong recommendation against
- Audiometric testing
- Laboratory testing: Strong recommendation against
- Magnetic Resonance Imaging (MRI) to rule out Pathology
- Shared decision making/ patient education.

## Treatment

- Oral Corticosteroids: Option
- Hyperbaric oxygenation (HBO) therapy: Option
- Other Pharmacologic therapy: strong recommendation against
- Outcomes assessment: Recommendation
- Rehabilitation: Strong Recommendation

(Chandrasekjar, 2019)

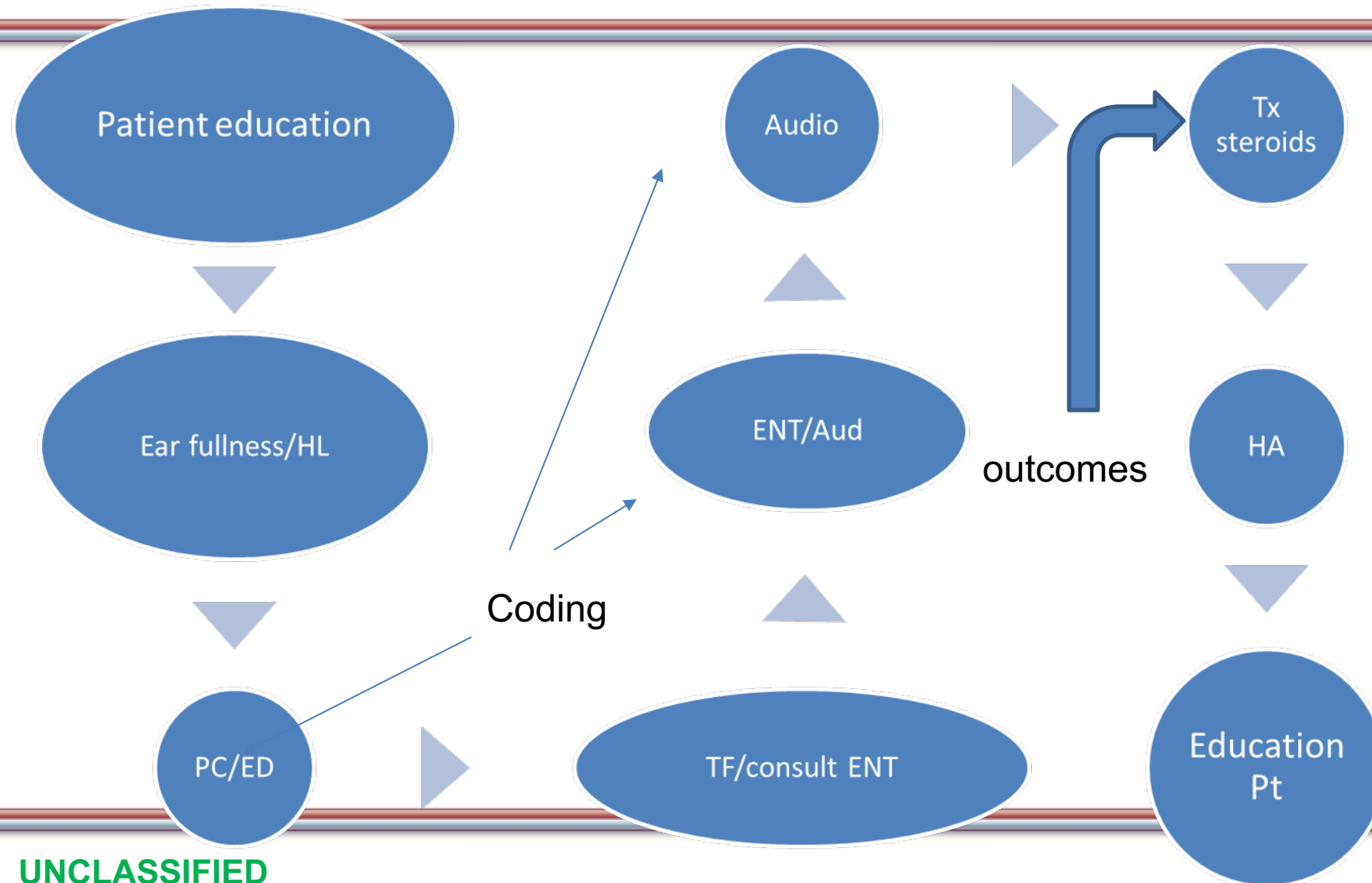


# HCE SSNHL Study

- Evaluate the percentage of patients with SSNHL being treated according to the AAO-HNS CPG.
- Assess cost of testing methods, unnecessary appointments, referrals and NOT recommended treatments/incorrect dosage of treatments.
- Evaluate provider education to their patients, follow-up and number of patients receiving amplification devices.
- Compare the percentage of patients with diagnosis of SSNHL to CPG definition
- Compare how many patients get educated on their diagnosis
- Compare how many patients received amplification devices



# Care Path SSNHL



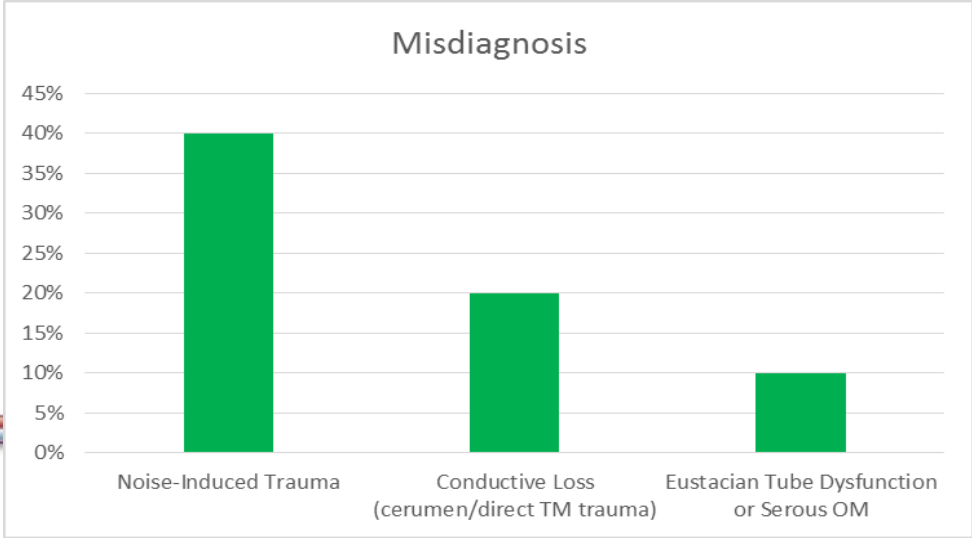
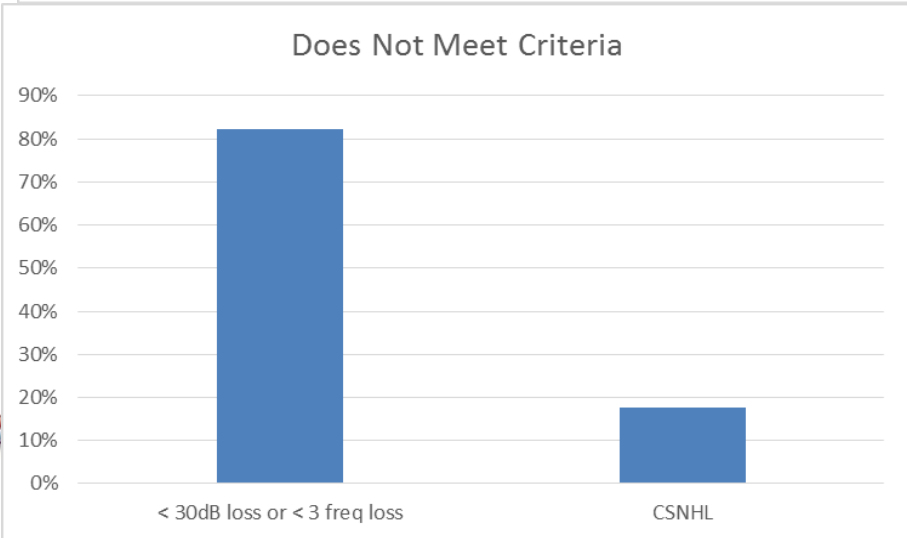
\*TF - Transfer



# HCE SSNHL



327 total subjects screened  
166 subjects excluded





## Sudden Sensorineural Hearing Loss Standard Procedures for the MHS

### Guidance for Primary Care

Recommendations from the Department of Defense Hearing Center of Excellence

[Hearing.health.mil](http://Hearing.health.mil)



# Gaps in Care

Specialties	GAP
PC, ED	Recognition of SSNHL and Referral Criteria
All Specialties	Documentation, Diagnosis Code, and Procedural coding
ENT	Standardized steroid dosage (oral and intratympanic [IT])
AUD	Standardized documentation of word list



# Primary Care Clinical Presentation

Patients present with a full or blocked ear after awakening. Tinnitus may occur as well as vertigo. They describe symptoms such as: “It feels like I have water in my ear” or “I can’t clear my ear.”

- Patients may not be able to lateralize the ear affected by hearing loss at first presentation. Precise questioning of the patient hearing status is warranted.
- You may ask “Has your hearing changed?” or “Can you use your mobile device/phone on the symptomatic ear?”



# Primary Care Presentation

- It is important to ask if patients have experienced recent trauma, external ear and canal pain, drainage, fever, or other systemic symptoms. Patients with SSNHL do not present with the above symptoms.
- Clinical exam is normal with no obvious explanation to the ear fullness or hearing loss (for example: cerumen impaction, otitis externa, otitis media, tympanic membrane perforation, etc).
- It is recommended that a Weber or Rinne test be performed with a 512-Hz/256-Hz tuning fork. See *Table 1. Recommended Technique and Associated Findings for Webber and Rinne Testing* for additional information.
  - In lieu of a tuning fork, clinicians may also ask the patient to hum, which will be heard in the better hearing ear, opposite of the symptomatic ear.

(McGee, 2007)



# Clinical Care

- Patients should be referred to ENT/Audiology on same day/within 72hrs.
- If Audiology is available they should be seen first.
- If warranted start oral prednisone at 60mg qd for 7-10 days with a taper.
- Every effort should be made to consult ENT/Audiology within 72 hours of starting medications.
- Imaging studies or labs are not warranted at this stage of evaluation.



# Clinical Care

- Primary care should use the code H91.90- Unspecified hearing loss.
- If Audiometric studies confirm SSNHL code H91.20 Sudden hearing loss.



# Tinnitus: Guidance for DoD Primary Care Providers

**Tara Zaugg, Au.D., C.C.C.-A.**  
**Audiologist/Research Investigator**  
**National Center for Rehabilitative Auditory Research**  
**VA Portland Health Care System**  
**Portland, Oregon USA**



**U.S. Department  
of Veterans Affairs**

Veterans Health  
Administration  
*Office of Research &  
Development*

**NCRAR**

**NATIONAL CENTER FOR REHABILITATIVE AUDITORY RESEARCH**



# Tinnitus: Guidance for DoD Primary Care Providers

## TINNITUS: GUIDANCE FOR DOD PRIMARY CARE PROVIDERS (PCP)

**TINNITUS** is internal sound (humming, ringing, buzzing, etc.) that is heard in the head or ears.

- **Primary tinnitus** is contained within the auditory pathways and is the most common type of tinnitus.
- **Secondary tinnitus** is caused by underlying conditions in the head or neck.

**Table 1. CLINICAL RECOMMENDATIONS**

Primary Tinnitus	How Often	Symptoms/Duration	Clinical Implications
Spontaneous (transient ear noise)	Random	Sudden tone in one ear, usually accompanied by sense of ear fullness and hearing loss. All symptoms resolve within 2-3 minutes	Normal physiological event experienced by almost everyone Recommend: No referral indicated. Reassure patient this is normal and not a sign of pathology.
Temporary	Follows tinnitus-inducing event—usually noise exposure but also some medications and chemicals	May accompany temporary change in hearing—can be a warning sign that temporary hearing loss has occurred. Can last 1 or more days	Indicates possible damage to inner ear Recommend: Educate about hearing conservation (e.g., use hearing protection, reduce exposure to hazardous noise, get periodic hearing test) and monitor symptoms.
Occasional	Less than weekly	Lasts at least 5 minutes	Referral not indicated unless there are otologic complaints Recommend: Educate about hearing conservation and monitor symptoms.
Intermittent	At least daily	Lasts at least 5 minutes	Recommend: (1) Refer for clinical



# Hearing “Nothing Can Be Done” from a Health Care Provider Sometimes Feels *Devastating*

- I’ve been told this \*many\* times from people who didn’t share their reaction with their provider.
- It is *usually* true that nothing can make the tinnitus quieter, but this message *must* be accompanied by the message that it is possible to feel better even if the tinnitus cannot be changed.



# Give Patients a Message That is Accurate and Leaves a Sense of Hope about Living with Tinnitus

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Intermittent	At least daily or weekly	Lasts at least 5 minutes	<b>Recommend:</b> (1) Refer for clinical audiology exam and brief tinnitus assessment; (2) Counsel re: hearing conservation
Constant	Always audible in quiet	Continuous sound	<b>Recommend:</b> Same as for intermittent tinnitus.

Table 2. RECOMMENDED REFERRALS (not to supersede local referral guidelines)

Symptoms—Tinnitus plus:	Refer to:	Urgency:
ANY of the below • Suicidal ideation • Obvious mental health problems	Mental Health or Emergency Care	Stat if suicidal ideation
ANY of the below • Facial palsy • Physical trauma	Emergency Care or Otolaryngology (ENT)	Stat
ANY sudden hearing loss (e.g., unexplained, associated with loud noise; patient may report "fullness" or "water in the ear")	Audiology and ENT	Within 24 hours, ENT treatment may need to start immediately
ANY of the below • Symptoms suggest secondary tinnitus (e.g., tinnitus that pulses with heartbeat) • Vestibular symptoms, ear pain, drainage, or malodor	ENT	Urgency determined by PCP & ENT; consult discussion is warranted to clarify urgency
ALL of the below • Symptoms suggest primary tinnitus (bilateral or unilateral) • No ear pain, drainage, or malodor • No vestibular symptoms • No unexplained sudden hearing loss or facial palsy	Audiology (refer to Table 1)	Non-urgent referral  Most people with tinnitus also have hearing loss—they should have their hearing tested

Give patients a message that is accurate and leaves a sense of hope about living with tinnitus.

- There is no drug treatment for tinnitus, and no vitamin or herb has been found to be any more effective than placebo.
- Tinnitus should not worsen unless the individual is exposed to loud noise, ototoxic drugs, or ototoxic chemicals.
- Sound enrichment is often helpful; in some cases hearing aids or specialized devices may be able to help.
- Learning coping skills can improve quality of life with tinnitus; patients may benefit from Cognitive Behavioral Therapy (CBT).
- Progressive Tinnitus Management (PTM) should be recommended if available (SEE: <https://www.ncrar.research.va.gov/education/documents/tinnitusdocuments/index.asp> OR <https://hearing.health.mil/For-Providers/Progressive-Tinnitus-Management>).

Version: November 2019

Created by the VA/DoD Tinnitus Working Group  
Contact: [dhs.ncr-j-9.lst.hoe-clinical-care@mail.mil](mailto:dhs.ncr-j-9.lst.hoe-clinical-care@mail.mil)



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# Clinical Recommendations

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# Recommended Referrals

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• Facial palsy		
• Physical trauma		
ANY sudden hearing loss (e.g., unexplained, associated with loud noise; patient may report "fullness" or "water in the ear")	Audiology and ENT	Within 24 hours, ENT treatment may need to start immediately
ANY of the below	ENT	Urgency determined by PCP & ENT; consult discussion is warranted to clarify urgency
• Symptoms suggest <b>secondary</b> tinnitus (e.g., tinnitus that pulses with heartbeat)		
• Vestibular symptoms, ear pain, drainage, or malodor		
ALL of the below	Audiology (refer to Table 1)	Non-urgent referral
• Symptoms suggest <b>primary</b> tinnitus (bilateral or unilateral)		
• No ear pain, drainage, or malodor		
• No vestibular symptoms		
• No unexplained sudden hearing loss or facial palsy		

Give patients a message that is accurate and leaves a sense of hope about living with tinnitus.

- There is no drug treatment for tinnitus, and no vitamin or herb has been found to be any more effective than placebo.
- Tinnitus should not worsen unless the individual is exposed to loud noise, ototoxic drugs, or ototoxic chemicals.
- Sound enrichment is often helpful; in some cases hearing aids or specialized devices may be able to help.
- Learning coping skills can improve quality of life with tinnitus; patients may benefit from Cognitive Behavioral Therapy (CBT).
- Progressive Tinnitus Management (PTM) should be recommended if available (SEE: <https://www.ncrar.research.va.gov/education/documents/tinnitusdocuments/index.asp> OR <https://hearing.health.mil/For-Providers/Progressive-Tinnitus-Management>).

Version: November 2019

Created by the VA/DoD Tinnitus Working Group  
Contact: [dha.ncr-j9.tet.hoe-clinical-care@gmail.com](mailto:dha.ncr-j9.tet.hoe-clinical-care@gmail.com)



# Recommended Referrals

**Table 2. RECOMMENDED REFERRALS** (not to supersede local referral guidelines)

Symptoms—Tinnitus plus:	Refer to:	Urgency:
<b>ANY</b> of the below <ul style="list-style-type: none"> <li>• Suicidal ideation</li> <li>• Obvious mental health problems</li> </ul>	Mental Health or Emergency Care	Stat if suicidal ideation
<b>ANY</b> of the below <ul style="list-style-type: none"> <li>• Facial palsy</li> <li>• Physical trauma</li> </ul>	Emergency Care or Otolaryngology (ENT)	Stat
<b>ANY</b> sudden hearing loss (e.g., unexplained, associated with loud noise; patient may report “fullness” or “water in the ear”)	Audiology and ENT	Within 24 hours, ENT treatment may need to start immediately
<b>ANY</b> of the below <ul style="list-style-type: none"> <li>• Symptoms suggest <b>secondary</b> tinnitus (e.g., tinnitus that pulses with heartbeat)</li> <li>• Vestibular symptoms, ear pain, drainage, or malodor</li> </ul>	ENT	Urgency determined by PCP & ENT; consult discussion is warranted to clarify urgency
<b>ALL</b> of the below <ul style="list-style-type: none"> <li>• Symptoms suggest <b>primary</b> tinnitus (bilateral or unilateral)</li> <li>• No ear pain, drainage, or malodor</li> <li>• No vestibular symptoms</li> <li>• No unexplained sudden hearing loss or facial palsy</li> </ul>	Audiology (refer to Table 1)	Non-urgent referral  Most people with tinnitus also have hearing loss—they should have their hearing tested



# Recommended Referrals for Sudden Hearing Loss

**Table 2. RECOMMENDED REFERRALS** (not to supersede local referral guidelines)

Symptoms—Tinnitus plus:	Refer to:	Urgency:
<b>ANY</b> of the below <ul style="list-style-type: none"> <li>• Suicidal ideation</li> <li>• Obvious mental health problems</li> </ul>	Mental Health or Emergency Care	Stat if suicidal ideation
<b>ANY</b> of the below <ul style="list-style-type: none"> <li>• Facial palsy</li> </ul>	Emergency Care or Otolaryngology (ENT)	Stat
<b>ANY</b> sudden hearing loss (e.g., unexplained, associated with loud noise; patient may report “fullness” or “water in the ear”)	Audiology and ENT	<b>Within 24 hours</b> , ENT treatment may need to start immediately
<b>ANY</b> of the below <ul style="list-style-type: none"> <li>• Symptoms suggest <b>secondary</b> tinnitus (e.g., tinnitus that pulses with heartbeat)</li> <li>• Vestibular symptoms, ear pain, drainage, or malodor</li> </ul>	ENT	Urgency determined by PCP & ENT; consult discussion is warranted to clarify urgency
<b>ALL</b> of the below <ul style="list-style-type: none"> <li>• Symptoms suggest <b>primary</b> tinnitus (bilateral or unilateral)</li> <li>• No ear pain, drainage, or malodor</li> <li>• No vestibular symptoms</li> <li>• No unexplained sudden hearing loss or facial palsy</li> </ul>	Audiology (refer to Table 1)	Non-urgent referral  Most people with tinnitus also have hearing loss—they should have their hearing tested



# Tinnitus: Guidance for DoD Primary Care Providers

## TINNITUS: GUIDANCE FOR DOD PRIMARY CARE PROVIDERS (PCP)

TINNITUS is internal sound (humming, ringing, buzzing, etc.) that is heard in the head or ears.

- Primary tinnitus is contained within the auditory pathways and is the most common type of tinnitus.
- Secondary tinnitus is caused by underlying conditions in the head or neck.

Table 1. CLINICAL RECOMMENDATIONS

Primary Tinnitus	How Often	Symptoms/Duration	Clinical Implications
Spontaneous (transient ear noise)	Random	Sudden tone in one ear, usually accompanied by sense of ear fullness and hearing loss. All symptoms resolve within 2-3 minutes	Normal physiological event experienced by almost everyone <b>Recommend:</b> No referral indicated. Reassure patient this is normal and not a sign of pathology.
Temporary	Follows tinnitus-inducing event—usually noise exposure but also some medications and chemicals	May accompany temporary change in hearing—can be a warning sign that temporary hearing loss has occurred. Can last 1 or more days	Indicates possible damage to inner ear <b>Recommend:</b> Educate about hearing conservation (e.g., use hearing protection, reduce exposure to hazardous noise, get periodic hearing test) and monitor symptoms.
Occasional	Less than weekly	Lasts at least 5 minutes	Referral not indicated unless there are otologic complaints <b>Recommend:</b> Educate about hearing conservation and monitor symptoms.
Intermittent	At least daily or weekly	Lasts at least 5 minutes	<b>Recommend:</b> (1) Refer for clinical audiologic exam and brief tinnitus assessment, (2) Counsel re: hearing conservation
Constant	Always audible in quiet	Continuous sound	<b>Recommend:</b> Same as for intermittent tinnitus.

Table 2. RECOMMENDED REFERRALS (not to supersede local referral guidelines)

Symptoms—Tinnitus plus:	Refer to:	Urgency:
ANY of the below • Suicidal ideation • Obvious mental health problems	Mental Health or Emergency Care	Stat if suicidal ideation
ANY of the below • Facial palsy • Physical trauma	Emergency Care or Otolaryngology (ENT)	Stat
ANY sudden hearing loss (e.g., unexplained, associated with loud noise; patient may report "fullness" or "water in the ear")	Audiology and ENT	Within 24 hours, ENT treatment may need to start immediately
ANY of the below • Symptoms suggest secondary tinnitus (e.g., tinnitus that pulses with heartbeat) • Vestibular symptoms, ear pain, drainage, or malodor	ENT	Urgency determined by PCP & ENT; consult discussion is warranted to clarify urgency
ALL of the below • Symptoms suggest primary tinnitus (bilateral or unilateral) • No ear pain, drainage, or malodor • No vestibular symptoms • No unexplained sudden hearing loss or facial palsy	Audiology (refer to Table 1)	Non-urgent referral  Most people with tinnitus also have hearing loss—they should have their hearing tested

Give patients a message that is accurate and leaves a sense of hope about living with tinnitus.

- There is no drug treatment for tinnitus, and no vitamin or herb has been found to be any more effective than placebo.
- Tinnitus should not worsen unless the individual is exposed to loud noise, ototoxic drugs, or ototoxic chemicals.
- Sound enrichment is often helpful; in some cases hearing aids or specialized devices may be able to help.
- Learning coping skills can improve quality of life with tinnitus; patients may benefit from Cognitive Behavioral Therapy (CBT).
- Progressive Tinnitus Management (PTM) should be recommended if available (SEE: <https://www.ncrar.research.va.gov/education/documents/tinnitusdocuments/index.asp> OR <https://hearing.health.mil/For-Providers/Progressive-Tinnitus-Management>).

Version: November 2019

Created by the VA/DoD Tinnitus Working Group  
Contact: [dha.ncr-j9.let.hoe-clinical-care@mail.mil](mailto:dha.ncr-j9.let.hoe-clinical-care@mail.mil)



# Tinnitus: Guidance for DoD Primary Care Providers

**Give patients a message that is accurate and leaves a sense of hope about living with tinnitus.**

- There is no drug treatment for tinnitus, and no vitamin or herb has been found to be any more effective than placebo.
- Tinnitus should not worsen unless the individual is exposed to loud noise, ototoxic drugs, or ototoxic chemicals.
- Sound enrichment is often helpful; in some cases hearing aids or specialized devices may be able to help.
- Learning coping skills can improve quality of life with tinnitus; patients may benefit from Cognitive Behavioral Therapy (CBT).
- Progressive Tinnitus Management (PTM) should be recommended if available (SEE: <https://www.ncrar.research.va.gov/ClinicianResources/IndexPTM.asp> OR <https://hearing.health.mil/For-Providers/Progressive-Tinnitus-Management>).



# Coding Guidance for Diagnosing Vestibular Disorders in the MHS

Recommendations from the  
Department of Defense  
Hearing Center of Excellence

Karen H Lambert, P.T., D.P.T., N.C.S.



# Background

- Diagnosing dizziness can be challenging
  - Multifactorial causes of dizziness
  - Varying interpretations of the word “dizziness”
- Misunderstanding the cause of dizziness can lead to misdiagnosis
  - Shift treatment paradigm
  - Delay appropriate treatment
  - Adversely influence Service Member’s readiness and job performance



# Recommendation

- Differentiate appropriate codes for use by primary care providers (PCP)
- Reserve specific codes for use after full, specialty-specific evaluation is complete



# Development of the Coding Guidance

- Created by the DoD Hearing Center of Excellence (HCE) in collaboration with Tri-Service representatives and subject matter experts
- Utilized 10<sup>th</sup> revision of the International Classification of Diseases (ICD-10) to standardize and provide guidance for diagnosing patients with dizziness in the DoD
- Approved by DHA Coding Workgroup and DHA Medical Coding Program in accordance with IPM 18-016

(DHA, 2020)



# Coding Guidance Available on HCE Website

<https://hearing.health.mil/>





# Coding Guidance Available on HCE Website

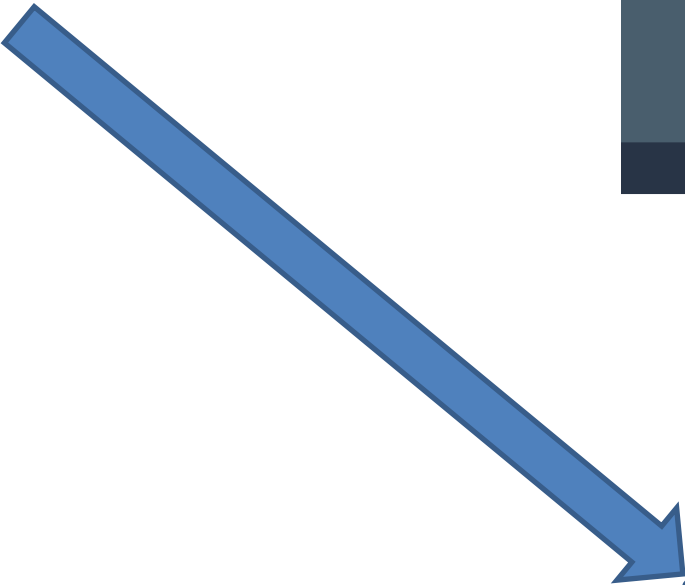
<https://hearing.health.mil/>

The screenshot shows the HCE website interface. The top navigation bar includes the HCE logo, the text 'DEPARTMENT OF DEFENSE HEARING CENTER OF EXCELLENCE', a search bar, and social media icons. Below this is a secondary navigation bar with links: ABOUT HCE, PREVENTION, RESEARCH, INFORMATION MANAGEMENT, FOR PROVIDERS, and RESOURCES. The 'FOR PROVIDERS' link is highlighted in red. A dropdown menu is open under 'FOR PROVIDERS', listing several options: Standards and Clinical Practice Guidelines, Hearing Evaluation & Treatment Solutions, DoD-VA Hearing Prosthetics Ordering System, Diagnostic and Coding Guidance (which is circled in blue), HCE Sponsored Educational Videos, Progressive Tinnitus Management, and Sprint 100 Instructions. A large blue arrow points from the left towards the 'Diagnostic and Coding Guidance' link. In the background, a banner for 'CORONAVIRUS COVID' is visible, along with a 'CLICK HERE FOR MORE INFORMATION' button. At the bottom, there are sections for 'TOPICS BY AUDIENCE' and 'FEATURED VIDEOS'.



# Coding Guidance Available on HCE Website

<https://hearing.health.mil/>



The screenshot shows the HCE (Hearing Center of Excellence) website. The header includes the HCE logo, the Department of Defense logo, and the text 'HEARING CENTER OF EXCELLENCE'. A search bar and social media links are also present. The main navigation menu includes 'ABOUT HCE', 'PREVENTION', 'RESEARCH', 'INFORMATION MANAGEMENT', 'FOR PROVIDERS', and 'RESOURCES'. The 'FOR PROVIDERS' section is expanded, showing a list of resources: 'Standards and Clinical Practice Guidelines', 'Hearing Evaluation & Treatment Solutions', 'DoD-VA Hearing Prosthetics Ordering System', 'Diagnostic and Coding Guidance' (highlighted in blue), 'HCE Sponsored Educational Videos', 'Progressive Tinnitus Management', and 'Sprint 100 Instructions'. The 'Diagnostic and Coding Guidance' section is further detailed, showing a list of documents: 'Audiology Coding Guidance', 'Sudden Sensorineural Hearing Loss - Audiology', 'Sudden Sensorineural Hearing Loss - Otolaryngology', 'Sudden Sensorineural Hearing Loss - Primary Care', and 'Vestibular Coding Guidance' (circled in blue). A large blue arrow points from the URL on the left to the 'Vestibular Coding Guidance' link.

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**DIAGNOSTIC AND CODING GUIDANCE**

These documents were created to ensure that consistent diagnostic evaluation, documentation and coding practices are used throughout the DoD by BHD and FBN Audiology clinics, among audiologists and Hearing Health Technicians, as well as by providers who evaluate and treat auditory/vestibular disorders. This will help to ensure that meaningful and correct data is being captured in the Joint Hearing Loss and Auditory System Injury Registry (JHASIR).

[Audiology Coding Guidance](#)  
[Sudden Sensorineural Hearing Loss - Audiology](#)  
[Sudden Sensorineural Hearing Loss - Otolaryngology](#)  
[Sudden Sensorineural Hearing Loss - Primary Care](#)  
[Vestibular Coding Guidance](#)

**FOR PROVIDERS**

- [Standards and Clinical Practice Guidelines](#)
- [Hearing Evaluation & Treatment Solutions](#)
- [DoD-VA Hearing Prosthetics Ordering System](#)
- [Diagnostic and Coding Guidance](#)**
- [HCE Sponsored Educational Videos](#)
- [Progressive Tinnitus Management](#)
- [Sprint 100 Instructions](#)



# Common Terminology

- Vertigo – sensation of motion when no motion is present; altered sensation of motion when motion occurs; often described as spinning, but can be translational, tilt, swaying, or linear
- Oscillopsia – illusion that the world is jiggling (bouncing) when patient moves
- Imbalance – difficulty and unsteadiness when walking
- Disequilibrium – altered sense of orientation to the world
- Near-syncope – feeling of almost fainting
- Lightheadedness – vague feeling in head as if becoming weightless



# General referral patterns

Symptoms	Suspected system	Referral suggestion
Acute spinning vertigo, hearing and tinnitus symptoms	Peripheral (inner ear) pathology	<ul style="list-style-type: none"><li>• ENT and audiology for vestibular workup and diagnosis</li><li>• Vestibular Physical therapy (PT) for symptom management</li></ul>
Imbalance, chronic or slow developing headache, other neuro symptoms	Central nervous system pathology	<ul style="list-style-type: none"><li>• Neurology for diagnosis</li><li>• PT for symptom management</li></ul>
Lightheadedness or near-syncope	Cardiovascular pathology	<ul style="list-style-type: none"><li>• Primary care team to workup and determine appropriate referral</li></ul>



# Coding Recommendations





# Summary of Codes

## ■ Summary reference sheet groups codes as:

- ☐ General codes – can be used by primary care clinician prior to diagnostic exams
- ☐ Peripheral vestibular codes – to be used after vestibular diagnostic exam has been performed
- ☐ Central pathology codes – to be used after neurological evaluation and diagnosis
- ☐ Other pathology codes
  - Do not recommend use of these codes
  - Should rarely be used

(HCE, 2020)

### Summary of Codes

Please note that this summary of codes is for quick reference purposes. It is recommended that providers carefully review symptoms and results of appropriate examinations prior to selecting the proper diagnosis.

<input checked="" type="checkbox"/> Diagnosis	ICD-10 Code
<b>General Codes</b>	
These codes to be used by a primary care clinician, prior to diagnostic exams.	
<input type="checkbox"/> Other Peripheral Vertigo	H81.39*
<input type="checkbox"/> Vertigo of Central Origin	H81.4*
<input type="checkbox"/> Unspecified Disorder of Vestibular Function	H81.9*
<input type="checkbox"/> Motion Sickness	T75.3XXz
<b>Peripheral Vestibular Codes</b>	
These codes to be used after diagnostic exams have been completed.	
<input type="checkbox"/> Benign Paroxysmal Positional Vertigo (BPPV)	H81.1*
<input type="checkbox"/> Meniere's Disease	H81.0*
<input type="checkbox"/> Vestibular Neuritis	H81.2*
<input type="checkbox"/> Labyrinthitis	H83.0*
<input type="checkbox"/> Labyrinthine Fistula/Perilymphatic Fistula	H83.1*
<input type="checkbox"/> Superior Semicircular Canal Dehiscence Syndrome	H83.8x9
<input type="checkbox"/> Acoustic Nerve Disorders	H93.3X
<input type="checkbox"/> Vestibular Schwannoma	D33.3
<b>Central Pathology Codes</b>	
These codes to be used after a neurological evaluation and diagnosis have been completed.	
<input type="checkbox"/> Cervical Vertigo	169.998
<input type="checkbox"/> Vertebrobasilar Artery Syndrome	G45.0*
<input type="checkbox"/> Migraine with Aura (formerly known as Basilar Migraine or Vestibular Migraine)	G43.1*
<b>Other Pathology Codes</b>	
Clinicians should replace these codes with similar codes, as these should rarely be used, or should be used secondary to other disease processes.	
<input type="checkbox"/> Dizziness/Giddiness	R42
<input type="checkbox"/> Vertiginous Syndrome in Diseases Classified Elsewhere	H82.*
<input type="checkbox"/> Labyrinthine Dysfunction	H83.2*
<input type="checkbox"/> Other Disorders of Vestibular Function	H81.8X3
<input type="checkbox"/> Aural Vertigo	H81.31*



# General Codes

- This summary (slides 14-17) includes codes intended for use by primary care providers, to accompany referrals to specialists who will diagnose or treat the patient's symptoms.
- Additional details are available in the guidance document.

## General Codes

These codes to be used by a primary care clinician, prior to diagnostic exams.

ICD-10 Codes In This Section
H81.39* — Other Peripheral Vertigo
H81.4* — Vertigo of Central Origin
H81.9* — Unspecified Disorder of Vestibular Function
T75.3XXS — Motion Sickness

(HCE, 2020)



# H81.39\* - Other Peripheral Vertigo

## General Codes

These codes to be used by a primary care clinician, prior to diagnostic exams.

ICD-10 Codes In This Section
H81.39* — Other Peripheral Vertigo
H81.4* — Vertigo of Central Origin
H81.9* — Unspecified Disorder of Vestibular Function
T75.3XXS — Motion Sickness

## ■ Presentation of vertigo/spinning may include:

- ☐ Sudden onset
- ☐ Concurrent hearing loss
- ☐ Nausea
- ☐ Nystagmus is horizontal or torsional
- ☐ Nystagmus is direction fixed and follows Alexander's law

## ■ Appropriate diagnostic code for primary care *before* referral to ENT/Audiology (aud) for differential diagnosis and vestibular rehabilitation for management

(HCE, 2020)



# H81.4\* - Vertigo of Central Origin

## General Codes

These codes to be used by a primary care clinician, prior to diagnostic exams.

ICD-10 Codes In This Section
H81.39* — Other Peripheral Vertigo
H81.4* — Vertigo of Central Origin
H81.9* — Unspecified Disorder of Vestibular Function
T75.3XXS — Motion Sickness

- Presentation of disequilibrium, swimming or imbalance may include:
  - ☐ Progressive onset
  - ☐ Purely vertical nystagmus
  - ☐ Nystagmus does not abate with fixation
  - ☐ Nystagmus changes direction
  - ☐ Other neurologic signs/symptoms
- Appropriate diagnostic code for primary care *before* referral to neurology or ENT for differential diagnosis and vestibular rehabilitation for management.

(HCE, 2020)



# H81.9\* - Unspecified Disorder of Vestibular Function

## General Codes

These codes to be used by a primary care clinician, prior to diagnostic exams.

ICD-10 Codes In This Section
H81.39* — Other Peripheral Vertigo
H81.4* — Vertigo of Central Origin
H81.9* — Unspecified Disorder of Vestibular Function
T75.3XXS — Motion Sickness

- Should replace a general dizziness code
- Appropriate diagnostic code for primary care when uncertain about central versus peripheral etiology
- Consider referrals to ENT/Audiology for testing and diagnosis, and to vestibular rehabilitation for management

(HCE, 2020)



# T75.3XXS- Motion Sickness

## General Codes

These codes to be used by a primary care clinician, prior to diagnostic exams.

ICD-10 Codes In This Section
H81.39* — Other Peripheral Vertigo
H81.4* — Vertigo of Central Origin
H81.9* — Unspecified Disorder of Vestibular Function
T75.3XXS — Motion Sickness

- Symptoms of nausea caused by motion, particularly when traveling by car, airplane, boat or train
- Appropriate diagnosis code for primary care
- Consider differential:
  - ☐ Migraine
  - ☐ Mal de débarquement syndrome

(HCE, 2020)



# Peripheral Codes

- This summary (slides 19-23) provides guidance for use of codes related to peripheral disorders.
- Primary care providers can diagnose and treat benign paroxysmal positional vertigo (H81.1\*) as their experience/training dictates.

These codes to be used after diagnostic exams have been completed.

ICD-10 Codes in this Section
H81.1* — Benign Paroxysmal Positional Vertigo (BPPV)
H81.0* — Meniere's Disease
H81.2* — Vestibular Neuronitis
H83.0* — Labyrinthitis
H83.1* — Labyrinthine Fistula/ Perilymphatic Fistula
H83.8x9 — Superior Semicircular Canal Dehiscence Syndrome
H93.3X — Acoustic Nerve Disorders
D33.3 — Vestibular Schwannoma

(HCE, 2020)



# Peripheral Codes

- For other peripheral vestibular disorders, referral for ENT/audiology and PT is recommended for differential diagnosis and follow-on care.
- Diagnostic evaluations by specialty and sub-specialty providers are recommended.
- Primary care should code H81.39\* to indicate "other peripheral vertigo."
- Key markers for the specific diagnoses are provided in the following slides.
- The guidance document provides additional diagnostic criteria for use by applicable providers.

These codes to be used after diagnostic exams have been completed.

ICD-10 Codes in this Section
H81.1* — Benign Paroxysmal Positional Vertigo (BPPV)
H81.0* — Meniere's Disease
H81.2* — Vestibular Neuronitis
H83.0* — Labyrinthitis
H83.1* — Labyrinthine Fistula/ Perilymphatic Fistula
H83.8x9 — Superior Semicircular Canal Dehiscence Syndrome
H93.3X — Acoustic Nerve Disorders
D33.3 — Vestibular Schwannoma

(HCE, 2020)



# Peripheral Vestibular Codes

These codes to be used after diagnostic exams have been completed.

ICD-10 Codes in this Section	
H81.1* — Benign Paroxysmal Positional Vertigo (BPPV)	
H81.0* — Meniere's Disease	
H81.2* — Vestibular Neuronitis	
H83.0* — Labyrinthitis	
H83.1* — Labyrinthine Fistula/ Perilymphatic Fistula	
H83.8x9 — Superior Semicircular Canal Dehiscence Syndrome	
H93.3X — Acoustic Nerve Disorders	
D33.3 — Vestibular Schwannoma	

Must have a positive positional test – if experience dictates, PCP may perform repositioning maneuver

Must meet all 4:

- Spontaneous episodes of vertigo
- Fluctuating hearing loss
- Tinnitus
- Aural fullness

(HCE, 2020)



# Peripheral Vestibular Codes

These codes to be used after diagnostic exams have been completed.

ICD-10 Codes in this Section	
H81.1* — Benign Paroxysmal Positional Vertigo (BPPV)	
H81.0* — Meniere's Disease	
H81.2* — Vestibular Neuronitis	
H83.0* — Labyrinthitis	
H83.1* — Labyrinthine Fistula/ Perilymphatic Fistula	
H83.8x9 — Superior Semicircular Canal Dehiscence Syndrome	
H93.3X — Acoustic Nerve Disorders	
D33.3 — Vestibular Schwannoma	

Sudden severe vertigo  
lasting days – no  
associated hearing  
changes or tinnitus;  
refer to ENT/aud/PT

Sudden severe vertigo  
lasting days – WITH  
associated hearing  
changes or tinnitus;  
refer to ENT/aud/PT

(HCE, 2020)



# Peripheral Vestibular Codes

These codes to be used after diagnostic exams have been completed.

ICD-10 Codes in this Section
H81.1* — Benign Paroxysmal Positional Vertigo (BPPV)
H81.0* — Meniere’s Disease
H81.2* — Vestibular Neuronitis
H83.0* — Labyrinthitis
H83.1* — Labyrinthine Fistula/ Perilymphatic Fistula
H83.8x9 — Superior Semicircular Canal Dehiscence Syndrome
H93.3X — Acoustic Nerve Disorders
D33.3 — Vestibular Schwannoma

Hearing loss may be sudden and profound or fluctuating; may follow physical trauma; refer to ENT/aud/PT

Vertigo and/or oscillopsia with loud noises or change in middle ear pressure; autophony; refer to ENT/aud

(HCE, 2020)



# Peripheral Vestibular Codes

These codes to be used after diagnostic exams have been completed.

## ICD-10 Codes in this Section

H81.1\* — Benign Paroxysmal Positional Vertigo (BPPV)

H81.0\* — Meniere's Disease

H81.2\* — Vestibular Neuronitis

H83.0\* — Labyrinthitis

H83.1\* — Labyrinthine Fistula/ Perilymphatic Fistula

H83.8x9 — Superior Semicircular Canal Dehiscence Syndrome

~~H95.3X — Acoustic Nerve Disorders~~

~~D32.3 — Vestibular Schwannoma~~

Clinical signs vary by degree of hearing loss, vertigo and/or tinnitus; this code should NOT be used by primary care – refer to ENT

Clinical signs vary in degree of hearing loss, tinnitus, vertigo and nystagmus - this code should NOT be used by primary care – refer to ENT, neurology, or neurosurgery

(HCE, 2020)



# Central Pathology Codes

- Slide 25 reviews specific diagnosis codes related to dizziness attributed to causes *other* than the peripheral vestibular system.
- Referral to neurology is recommended for differential diagnosis and treatment.
- Primary care should code H81.39\* to indicate "other peripheral vertigo."
- Key markers for the specific diagnoses are provided.
- The guidance document provides additional diagnostic criteria for use by applicable providers.

These codes to be used after a neurological evaluation and diagnosis have been completed.

ICD-10 Codes in this Section
169.998 — Cervical Vertigo
G45.0* — Vertebrobasilar Artery Syndrome
G43.1* — Migraine with Aura (formerly known as Basilar Migraine or Vestibular Migraine)

(HCE, 2020)



# Central Pathology Codes

These codes to be used after a neurological evaluation and diagnosis have been completed.

## ICD-10 Codes in this Section

169.998 — Cervical Vertigo

G45.0\* — Vertebrobasilar Artery Syndrome

G43.1\* — Migraine with Aura (formerly known as Basilar Migraine or Vestibular Migraine)

Dizziness associated with neck movement; refer to neuro, ENT or PT for evaluation and management

Dizziness, vision changes, numbness/tingling, slurred speech; refer to neuro/neurosurgery

Must meet specific criteria of International Classification of Headache Disorders; refer to neuro or ENT

(HCE, 2020)



# Other Pathology Codes

CODE	CONSIDER	WHO CAN USE
R42 – dizziness/giddiness	H81.4(central disorder) H81.39 (peripheral vertigo)	Primary care, ENT, audiology, neurology, neurosurgery, PT
H82 – vertiginous syndrome in diseases classified elsewhere	Only to be used when <b>secondary</b> to another disease process	ENT, neurology
H83.2 – labyrinthine dysfunction	For use <b>after</b> vestibular laboratory tests confirm hypofunction	Audiology
H81.8X3 – other disorders of vestibular function	H81.9 (unspecified disorder of vestibular function) H81.39 (peripheral vertigo) H81.4 (central vertigo)	Audiology, ENT, neurology, PT
H81.31 – aural vertigo	H81.39 (peripheral vertigo)	DO NOT USE

(HCE, 2020)



# Key Takeaways

- Familiarize yourself with appropriate treatment and referral for patients with SSNHL, tinnitus and vestibular disorders.
- Hearing the message “nothing can be done” about tinnitus feels devastating for some patients. Explain to patients who are bothered by tinnitus that it is possible to improve quality of life with tinnitus even if the tinnitus does not change.
- Improper coding of vestibular disorders leads to delays in treatment and often improper referral of Service Members with dizziness.



# References

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# Questions



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