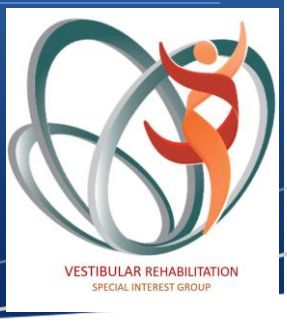
Vestibular Rehabilitation SIG

American Physical Therapy Association/Neurology Section

In this Issue:



Message from the Chair

Anne K. Galgon, PT, PhD, NCS
Vestibular Rehab SIG Chair

Advancing Vestibular Rehabilitation Practice

I was again so pleased to see the large number of individuals attending our CSM business meeting in San Antonio this past February. There was also great turn out at all the CSM Vestibular programming sessions and our Annual Vertigo-go Dinner. The high level of participation continues to confirm that there is still a great need to educate and serve our members who have specific interest in Advancement of Vestibular Rehabilitation practice. We remain one of the fastest growing groups within the Academy of Neurologic Physical Therapy (ANPT).

This year the Vestibular Rehabilitation SIG created a new vision statement, updated our mission and set priorities for the upcoming year. Our vision is to have **"Accessible, quality care for persons with vestibular disorders."** We felt strongly that by supporting and creating initiatives that advance the physical therapy practice of vestibular rehabilitation, we move towards this vision. Our updated mission is available on our Website

For more information go to:
http://www.neuropt.org/go/special-interest-groups/vestibular-rehabilitation

Message from the Chair (cont.)

http://neuropt.org/special-interest-groups/vestibular-rehabilitation. We prioritize three major objectives for the 2017-2018 year. The objectives are to:

- Develop strategies to collect and monitor reimbursement problems in order to develop solutions that will promote accessibility of care,
- Survey academic institutions and make recommendations for Entry-level education for vestibular rehabilitation, and
- Develop diverse education opportunities to advance practice.

Since CSM we have seen good progress on these objectives. **Lisa Dransfield** and the Reimbursement Advocacy Committee have created a plan to solicit information on billing and reimbursement problems related to Vestibular rehabilitation. This effort supports our vision of having accessible care for individuals with vestibular disorders. This newsletter contains information on some of the findings and provides recommendations in our Coding Challenge Report. We continue to remind members, through the Abstract of the Week, to report billing and reimbursement issues. Only with collaborative efforts can we hope to determine patterns and solutions to help clinicians at the local and national level. Thank you to those who have provided information and are assisting in this effort.

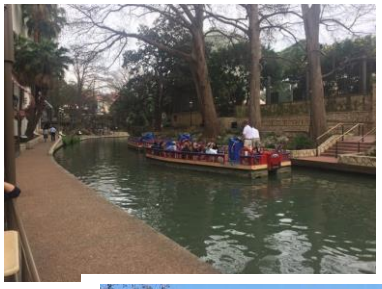
The Entry-Level Vestibular Rehabilitation Education Committee (**Anne Galgon, Diane Wrisely, Andrew Littman, Holly Roberts, Chuck Plishka, Lisa Dransfield, and Lisa Heusel-Gillig**) are building an online survey to determine content currently taught in entry-level PT education. The committee will target a pilot distribution to small number of DPT Programs for this summer. Our goal is to have a large distribution to all programs by the end of 2018. The ultimate objective is to make recommendations for DPT education.

There are several groups that are work on creating a variety of educational opportunities. We maintain active services to inform members of current research through the Abstract of the Week and Dizzy Pub Fare. We have revitalized our Podcast Committee and will begin updating and producing new podcasts. The committee has updated our recording software and website links in order to make better quality and more accessible podcasts. Look for information in the coming weeks. The ANPT continues to host 2 introductory and 2 advance vestibular rehabilitation regional face to face courses each year and supports multiple programs at CSM. This newsletter reviews some of the programs for members who are not able to attend. **Rachel Wellons** and our new online education committee have created a plan for expanding education programs through the ANPT Synapse Learning Center. Additionally, as I reported in the last newsletter, the most exciting upcoming educational opportunity will be the first **International Conference in Vestibular Rehabilitation,** which will take place in Chicago, on August 17-19, 2018. The goal of the conference is to bring international and national clinical experts and scientists working in vestibular disorders together, in one forum, in order to inform and advance the practice of vestibular rehabilitation. I specifically to thank **Susan Whitney, Becky Olson Kellogg, and Sandy Rossi** for all of their ongoing efforts and the support of the ANPT board in developing this Conference. An announcement for this conference has been posted on the website.

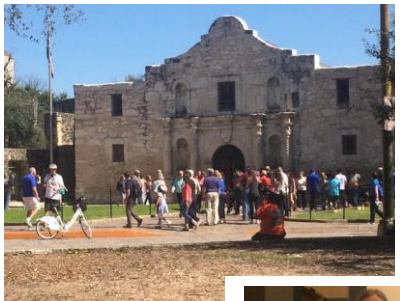
Message from the Chair (cont.)

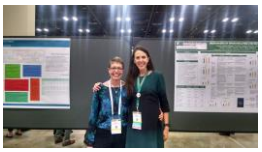
At CSM we recognized several people for their services. Of note, **Becky Bliss** has served on the nominating committee for three years and steps down as of July 1, 2017. Fortunately, she will continue to be a vital member by serving as the Fact Sheet Coordinator and participating on several other committees. **Matt Scherer**, who has maintained the Dizzy Pub Fare since 2011, has successful passed on his duties to keep our members up to date on current literature. I am particularly pleased to recognize **Becky Olson Kellogg,** the recipient of the **Vestibular Rehabilitation SIG Service Award,** for her major contributions to the SIG. This newsletter presents a brief summary of her contributions. I want to thank Becky, Becky, Matt and all the members who keep this SIG going.

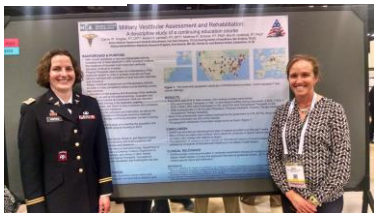
We were also successful in recruiting several young energetic individuals to joined our group. Some volunteers are taking over positions from members who have contributed for many, many years. Some have also taken on new roles and initiatives or revitalize services that support our vision. I want thank and welcome the following people, who joined our leadership group; **Michaela Bundy** (New Member Coordinator), **Nikki DeSalvio** (Student Member Coordinator), **Maureen Clancy** (Chair of Podcast committee), **Alisson Miller** (Podcast Committee), **Elizabeth Scott and Kim DeChant** (Dizzy Pub Fare Committee), and **Linda D'Silva** (Nominating Committee). Other new members have been recruited to work behind the scenes in smaller roles that support the podcasts, fact sheets, website, social media and our abstract of the week. The vital work of the VR SIG depends on our members contributions. Our younger members bring new ideas and perspectives that will keep us current and valuable to our members in the future. If you are interesting in participating in the group's efforts to advance the practice of vestibular rehabilitation, contact me, galgonanne56@gmail.com or one of our leaders from the leadership page http://neuropt.org/special-interest-groups/vestibular-rehabilitation/leadership-team.









Becky Olson Kellogg, PT, DPT, GCS CEEAA receives 2017 Vestibular Rehabilitation SIG Service Award

Becky Olson Kellogg was the recipient of the 2017 Vestibular Rehabilitation Service Award because of her ongoing and major contributions to the VR SIG and the growing field of vestibular rehabilitation. Besides being an excellent clinician and educator, she has shown great professionalism and perseverance that have resulted in getting work done. She has been a member of the Vestibular special interest group since 1992 and initially served on our nominating committee from 2009 to 2011. The Special Interest Group particularly wants to acknowledge that she created and was the first coordinator of our successful Abstract of the Week service, beginning in 2010. Becky has impressed us with her organizational skills when she directed the initial investigation into vestibular rehabilitation certification possibilities and subsequently developed the proposal for a Vestibular Rehabilitation Specialization to the ANPT. This ultimately led to the development of the description of Advance Practice/Specialization Taskforce, of which she continues to be a vital member. The outcome of this work will have a dramatic impact on vestibular rehabilitation practice. Additionally, we are so pleased that she has taken a leadership role in the upcoming International Conference for Vestibular Rehabilitation. It for these reasons and many more that we recognize Becky.

Currently Becky is the Associate Program Director and Assistant Professor, Division of Physical Therapy at the University of Minnesota, where she is also the director of the Physical Therapy Residency Program in Gerontology and Graduate Faculty in the University of Minnesota Program in Gerontology. She graduated with an BS in Physical Therapy from the University of Minnesota in 1992 and earn her DPT from Boston University in 2005.

Thank you, Becky! And congratulations!

PRIVATE PAYERS AND THE "CODING CHALLENGE"

Lisa Dransfield, PT, DPT, NCS

There are a number of factors that must be considered when coding and billing for vestibular rehabilitation services through third-party payers (insurance companies). For most outpatient settings, therapists must be credentialed with the individual payers and enter into a contract with them in order to provide therapy services. This means the therapist is willing to abide by that particular insurance company's policy on coding, billing, and even reimbursement. This includes the payer's guidelines for vestibular rehabilitation.

Recall that the CPT coding system was developed and is updated annually by the American Medical Association (AMA); thus, the AMA owns and maintains the CPT coding system. "CPT codes predominantly describe medical services and procedures performed by physicians and non-physician professionals." (Coding and Payment Guide, For the Physical Therapist: An essential coding, billing, and reimbursement resource for the physical therapist, 2016). The AMA further determines which CPT codes can be provided under supervision, under constant attendance, and which require one-on-one contact by the PT. Since all insurance carriers utilize the CPT codes to pay therapists for outpatient services, the principles of timed and untimed codes, as well as, any other code specifics apply.

The large carriers implement policy for vestibular rehabilitation based on clinical and medical practice guidelines that determine a vestibular patient's medical coverage. In an ideal world, the private insurers would make benefit coverage determinations based on evidence, review of literature, and clinical practice guidelines. Unfortunately, this is not always the case.

One of the more common themes that therapists are reporting is denial of CPT code 95992, Canalith Repositioning Procedure, the appropriate code when maneuvers are performed to decrease or eliminate symptoms of BPPV. Therapists are substituting code 97112, Neuromuscular Re-education, in an effort to get paid. (According to the 2016 Coding and Payment Guide for the Physical Therapists, Medicare *does* permit physical therapists to bill 97112 for canalith reposition services). Because the insurance industry is unregulated, specifics regarding medical policy are left to the discretion of the carriers. For instance, some workman compensation carriers will only pay for certain codes for physical therapy despite what is actually performed. If the therapist wants to get paid, he/she will abide by the insurance company's directives, even if they're not representative of what the therapist actually provides. Other commercial payers have denied CPT code 95992, because their policy states it is a medical code performed by medical doctors. And still, two of the larger third-party payers, Aetna and Blue Cross/Blue Shield, do not even include 95992 on their list of covered treatments and procedures provided by qualified physical therapists. Coverage appears to be predicated on whether "bones" are involved in the therapy. Herein lies the physical therapist's dilemma. Get reimbursed in a timely, albeit partially correct manner, or prepare for denials because the private payers have not updated their policies in regards to vestibular rehabilitation provided by physical therapists.

PRIVATE PAYERS AND THE "CODING CHALLENGE" (cont.)

The key is education. First, vestibular therapists need always implement current best evidence for vestibular rehabilitation and educate the public, medical doctors and insurers on clinical practice guidelines. Physical therapists must become experts on ICD-10 codes and well-versed on the current rules for application of CPT codes. At the very least, therapists must be privy to what is being billed, covered, and denied. Therapists cannot depend solely on a billing department to advocate for proper billing, coding and reimbursement in vestibular rehabilitation. The APTA website, manuals, and continuing education seminars are recommended to obtain a working knowledge from which to proceed. Sometimes, CRT is denied simply because the therapist neglects to use the correct BPPV code; for example, some insurance companies do not recognize unspecified laterality in BPPV as a billable code. Remember that CRT is an untimed code that is billed only one time per session, despite the number of canals affected and treated. If possible, avoid coding unspecified laterality in BPPV.

Most importantly, therapists must be willing to educate the private payers and even CMS (Centers for Medicare and Medicaid Services) by contacting the appropriate representatives to incite medical policy revisions based on evidence. A victory for all therapists treating vestibular patients occurred in 2013 when two physical therapists, Shayla Mclean and Barbara Young appealed to the National Government Services of Medicare to change their policy that denied coverage of VOR retraining in MN. Shayla and Barbara reviewed current literature on VOR/gaze stabilization and drafted a Local Coverage Determination (LCD) reconsideration to the National Government Services (NGS) in MN. They submitted twenty-eight references. Finally, in 2014, NGS confirmed that, indeed, there was sufficient evidence to support VOR training when clinically indicated! NGS changed their coverage of outpatient services, citing that CPT code 97112, Neuromuscular Re-education, properly captures Vestibular Ocular Reflex Training and would no longer be considered a non-covered service. Their Local Coverage Determination was revised and implemented immediately. This was a victory for patients with vestibular impairments and the therapists who treat them.

CALL FOR NEWSLETTER CONTRIBUTORS!!!

Do you want to get involved with your SIG?
Consider contributing to the newsletter!!

There are many ways to contribute and get involved. You can write an article on a topic of your choosing or an appropriate topic could be assigned to you. If you are interested in getting involved with the newsletter, please contact Betsy Grace Georgelos at bggeorgelos@gmail.com or Debbie Struiksma PT, NCS at dstruiksma77@aol.com.

Save the Date:

International Conference of Vestibular Rehabilitation

WHERE: HILTON PALMER HOUSE HOTEL, CHICAGO, IL

WHEN: AUGUST 17-19, 2018

SPONSORED BY: THE ACADEMY OF NEUROLOGIC PHYSICAL THERAPY

LEVEL OF CONTENT: ADVANCED LEVEL MATERIAL

VR SIG CALL FOR NOMINATIONS 2017-2018

Karen M. Skop, PT, DPT, MS
Nominating Committee Chair

Are you, or someone you know, toying with the idea of getting more involved? The Vestibular SIG has 2 elected officer positions on the slate this year. In my own personal experience, being involved has changed my behaviors, expectations and personal growth as a Physical Therapist. My story began as a young graduate student. The University of Miami encouraged, and paid for, our membership with the APTA. Following graduation, I was involved at the state level as an Assembly Representative. I held this duty for about 5 years, then slowly dropped out as life, work, family took more of my time. I let my membership lag over the next 8 years! Then, as the Veteran's Administration, my current employer, developed both an orthopedic and neurological residency program, I felt it was my duty as a mentor and role model to re-ignite my activity in the APTA.

In 2014, I contacted the Vestibular SIG and asked, "what can I do to be involved"? Dr. Anne Galgon led me to the Nominating Committee members, Dr. Lisa Dransfield, Dr. Lisa Gillig and Dr. Becky Bliss, who all embraced my interest. After 2 years of service, I am now the Nominating Committee Chair. This involvement has allowed me to participate with our monthly updates and conference calls from one of the most active SIG's within the Academy of Neurological Physical Therapy. My involvement allowed me to engage with the vestibular SIG podcasts, program development, and clinical practice guideline for vestibular hypofunction taskforce for dissemination plus countless networking opportunities. I feel as though these past few years have been a huge leap in my professional development and I would encourage YOU to consider taking that leap too.

We have 2 positions open for this year's election. Both positions are a 3-year term:
1) **Nominating Committee** – responsibilities include:
• Preparing a slate of candidates for open SIG positions each year
• Helping to coordinate and facilitate the election process
• The senior member of the Committee serves as Chair of the Committee during the third year of service

2) **Secretary** – responsibilities include:
• Maintaining records of all SIG meetings and conference calls
• Submits minutes of all SIG meetings to SIG officers and the Executive Officer
• Attends the SIG meeting with the section Vice President at CSM
• Assists the Chair in the preparation and submission of a yearly plan for the SIG to the Board of Directors
• Coordinates updating of Policy and Procedures Manual with the Vice President of the Neurology Section

VR SIG CALL FOR NOMINATIONS 2017-2018 (cont.)

If you or someone you know is interested in being nominated for one of these positions, please contact any of the Nominating Committee Officers. We look forward to hearing from you!

Karen M. Skop, PT, DPT, MS
skpannullo@gmail.com
Karen.skop@va.gov

Kurt van der Schalie, PT, DPT
kurt.vanderschalie@yahoo.com

Linda D'Silva PT, PhD
Linda.DSilva@rockhurst.edu

We would also like to welcome and congratulate our newest member of the VR SIG Nominating Committee, Dr. Linda D'Silva. Dr. D'Silva comes to us from Kansas, a clinical expert in the area of BPPV and diabetes. Welcome Linda!

Personally, a HUGE thanks to our outgoing SIG leader Dr. Becky Bliss. You have been a great asset to the SIG's goals and I know your activity within the SIG is sure to continue.

We would also like to recognize those individuals who were nominated during this past year's election, **Dr. Amelia Siles**, and **Dr. Jasmine Jackson**. We thank you for your dedication to our profession and look forward to your continued involvement in the Vestibular Rehabilitation SIG.

Upcoming APTA Meetings

CSM

CSM 2018
February 21-24, 2018 – New Orleans, Louisiana

CSM 2019
January 23-26, 2019 – Washington, DC

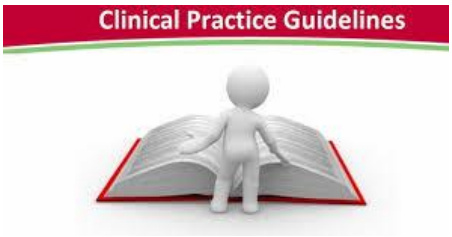
CSM 2020
February 12-15, 2020 – Denver, CO

CSM 2021
February 24-27, 2021 – Orlando, FL

NEXT Conference & Exposition

NEXT 2018
June 27-30, 2018 - Orlando, FL

NEXT 2019
June 12-15, 2019 - Chicago, IL



Clinical Practice Guidelines for Peripheral Vestibular Hypofunction (CPG)

Hall CD, et al. Vestibular Rehabilitation for Peripheral Vestibular Hypofunction: An Evidence-Based Clinical Practice Guidelines. *JNPT*. 2016; 40:124-155.

The **Clinical Practice Guidelines for Peripheral Vestibular Hypofunction (CPG)** was developed from a systematic critical appraisal of peer-reviewed literature. The intent of the CPG is to help rehabilitation professionals optimize care for persons with symptoms due to peripheral vestibular hypofunction.* The CPG can also be utilized to help educate other health care practitioners about vestibular rehabilitation (VR) and develop collaborative relationships to reduce unnecessary delays in patient referrals. The CPG is only intended to guide care and not to be a legal standard of care.

Based on the highest-quality evidence available, the CPG authors developed **10 action statements** and made **research recommendations** for each statement. This article has summarized this information to help rehabilitation professionals know WHO can benefit from VR, HOW to treat persons with peripheral vestibular hypofunction, and WHEN it is appropriate to provide care.

Action Statements 1 – 3 and 10 guide WHO can benefit from VR and should be offered care. Rehabilitation professionals should offer VR to patients with symptoms due to acute (first 2 weeks from onset), subacute (after first 2 weeks and up to 3 months from onset), or chronic (after 3 months) unilateral hypofunction or bilateral hypofunction, including those within the pediatric population. Strong evidence indicates that VR, when appropriately prescribed, reduce reports of dizziness/vertigo, gaze instability, and imbalance and can shorten episodes of care. Subsequently, VR has been shown to improve activities of daily living and quality of life as well as reduce psychological distress and fall risk. The potential risks of VR can be an increase in cost and time for patients who have to travel for care and/or can cause an increase in symptoms at treatment onset. Additionally, neck pain, motion sickness, and/or nausea may be side effects of treatment. Although most patients benefit from participating in VR, a small percentage of patients' symptoms do not improve or may worsen. Patients with cognitive, learning, or general mobility deficits or active Meniere's disease may be possible exclusions for VR because these comorbidities may impede meaningful application of exercise strategies.

The CPG recommends that the areas of research that are needed for action statements 1 – 3 and 10 should examine: a) early versus delayed intervention to better understand the critical period for optimal vestibular compensation, b) factors that predict which patients will or will not recover without VR, c) outcomes in persons with semicircular canal versus otolith organ damage, d) impact of the magnitude and range of hypofunction relative to functional recovery, e) outcomes in children with confirmed vestibular dysfunction, f) determine the critical period for providing VR in children with vestibular dysfunction, such for those who are receiving cochlear implants, g) VR over time with longitudinal studies, and h) the concept of return to work relative to type impairment and job

Clinical Practice Guidelines for Peripheral Vestibular Hypofunction (CPG) (continued)

requirements, need for job modification, criteria for return to work or disability assignment, and indicators for return to safe driving.

Action Statements 4 – 7 guide HOW to treat patients with peripheral vestibular hypofunction. Since the primary approach to management of patients with peripheral vestibular hypofunction is with exercise, it is important to know that there is moderate evidence that supports this practice. Based on the best available research, the CPG recommends that rehabilitation professionals provide targeted exercise strategies to address identified impairments and functional limitations. Evidence has demonstrated treatment effectiveness when using the following exercise strategies: 1) gaze stability exercises based on principles of adaptation (involves head movements while maintaining focus on a target) and of substitution (promotes use of alternative sensory input to substitute for missing vestibular function) to promote visual fixation when the head moves, 2) habituation exercises to decrease sensitivity to symptoms provoked by head movement, and 3) balance and gait training that incorporates use of substitution techniques, changes in base of support, weight shifting, and/or varying the activity with head turns, secondary tasks, and virtual reality for the purpose of challenging the center of gravity control to improve stance and gait.

It is important that rehabilitation professionals be aware that there is strong evidence that voluntary saccadic or smooth pursuit eye exercises, used while the head remains stationary, should not be offered in isolation as gaze stabilization exercises. Studies have shown there are poorer outcomes in patients that perform only voluntary saccadic or smooth pursuit eye without head movement. These ineffective exercises, not only increase the financial burden for patients, but delay patients from receiving exercises that have demonstrated effectiveness.

When deciding whether patients should participate in a customized, supervised exercise program as compared to performing generic exercises and/or solely home-based exercises, there is moderate evidence demonstrating that patients with peripheral vestibular hypofunction have a preponderance of benefit as compared to harm when using a customized, supervised program that incorporates home-based exercises. Research has shown that this type of program can promote adherence as compared to participation in solely home-based exercises (evidence of higher dropout rate when unsupervised). Also, without feedback from a therapist during exercise, the patients may under- or over-comply with the exercise prescription resulting in lack of progress or increased symptoms. Patients with cognitive or moderate-severe mobility deficits or are fearful of falling may need supervision to benefit from VR. There should be thoughtful consideration of the time and money that is required of patients when they participate in supervised VR. This conflict may play a role in whether patients would prefer to participate or not, especially if they live long distances from the therapy location.

Regarding dosage of treatment for patients with peripheral vestibular hypofunction, there are only a few studies that have examined the effects of frequency and intensity of home-based programs using gaze stability exercises. Based on best practice and guided by the evidence expert opinion

Clinical Practice Guidelines for Peripheral Vestibular Hypofunction (CPG) (continued)

recommends the following as the optimal home-based exercise dose using gaze stability exercises:

- Three times per day for at least 12 minutes for acute and subacute
- Three times per day for at least 20 minutes for chronic

Even though providing the appropriate exercise dose may lead to improved outcomes, there is a risk of temporarily increasing symptoms during and after exercise, and especially during acute stage, there can be a risk of increased nausea/emesis. Keep in mind that some physicians may delay exercises, during early postoperative stage, because of risk of bleeding or cerebrospinal fluid leak.

The CPG recommends that the areas of research that are needed for action statements 4 - 7 should examine: a) the effectiveness of different types of vestibular exercises in large clinical trials to determine optimal exercise approaches, b) the adherence of patients by including measures to understand the impact of supervision and incorporate intent-to-treat designs to understand dropout rates related to supervision, and c) the impact of frequency, intensity, time, and type of exercises on VR outcomes and include methods to determine the difficulty of exercises and systematic exercise progression.

Action Statements 8 and 9 guide WHEN to treat patients with peripheral vestibular hypofunction.

Based on a range of weak to strong evidence, there are several non-disease-related factors that affect the decision as to when to offer care to patients who have symptoms due to peripheral vestibular hypofunction. For example, age and gender are factors that do not affect outcomes. Whereas, if patients have comorbidities, such as anxiety, migraine, or peripheral neuropathy, these factors may have a negative impact on outcomes. Also, inappropriate use of vestibular suppressants may negatively impact recovery. Patients who take these medications often require a longer duration of therapy to achieve the same benefit as compared with those not using medications.

When deciding when to begin treating patients, evidence supports early initiation of VR based on time from symptom onset because there is potential for harm related to quality of life and risk of falls if there is a delay in initiation of care. However, even though research has been shown to demonstrate better outcomes with earlier intervention, those with chronic symptoms may be offered VR because evidence has shown that this population also will benefit from care.

There are no studies that have examined how to decide the overall length of rehabilitation for patients without significant comorbidities. Based on expert opinion, the CPG provides a general recommendation for treatment duration, as:

- One time per week for two to three sessions for acute and subacute unilateral hypofunction
- One time per week for four to six sessions for chronic unilateral hypofunction
- One time per week for eight to 12 sessions for bilateral hypofunction

Additionally, there are no studies that have specifically examined when to stop VR for patients with

Clinical Practice Guidelines for Peripheral Vestibular Hypofunction (CPG) (continued)

patients with peripheral vestibular hypofunction. Based on expert opinion, the CPG recommends clinicians use the following reasons when making decisions about stopping or deferring therapy:

- Primary goals met, plateau reached, or symptom resolution
- Non-adherence or patient choice
- Status deterioration or prolonged symptom increase
- Progressive, fluctuating, or unstable vestibular conditions (eg, vestibular schwannoma, episodes of spontaneous vertigo, Meniere's, unrepaired perilymphatic fistula) that is not showing progress with rehabilitation
- Comorbid musculoskeletal, neurologic, cardiac, visual, cognitive, psychological, disability-related condition, and severe migraine, which affects ability to stand or perform exercises

Adverse symptoms, like dizziness, nausea, disorientation, and stress have been reported as increasing during the first one to two weeks of intervention, but should not necessarily be considered a reason for stopping therapy because the symptoms usually subside. Also, it is recommended that before stopping therapy for patients who remain symptomatic or have not met their goals, consultation with another vestibular rehabilitation professional is advisable. There may be a risk of causing harm by prematurely stopping treatment before maximum gains have been achieved. Conversely, there may be a cost to the payer and patient with protracted treatment. Additionally, patients with impaired cognition or moderate-severe mobility deficits, those who have a moderate-severe sensitivity to exercise, or those taking vestibular-suppressant medication may need greater number of sessions regardless of time from onset or severity of the vestibular problem.

The CPG recommends that the areas of research that are needed for action statements 8 - 9 should examine: a) the optimal duration of VR for favorable outcomes and b) factors that impact functional recovery.

To find the full article, one-page summaries for rehabilitation professionals and physicians, assessment/treatment algorithms, and patient fact sheets regarding the CPG, go to: http://www.neuropt.org/professional-resources/clinical-practice-guidelines/vestibular-hypofunction.

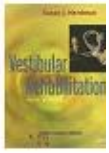
*This CPG does not include physical therapy management recommendations for Benign Paroxysmal Positional Vertigo.

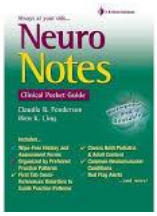
PMID: 26913496

CSM 2017
RAFFLE GIVEAWAYS

We would like to acknowledge and send a sincere *thank you* to the individuals and companies, listed below, who generously contributed to the Raffle Give-Aways this year! We hope you can join us for our business meeting next year at CSM 2018

- Arielle Coopersmith won **Micromedical RealEyes** Goggles and computer system
  Donated by Micromedical Technologies, Inc.
- Britta Smith won an **APTA Learning Center Gift Certificate**
  Donated by the APTA
- Dilnoza (Dina) Ahrorova won "**A Clinicians Guide to Balance and Dizziness"**
  Donated by Charles Plishka and Tony Schiavo, SLACK Incorporated





- Nikki DiSalvio won **"Vestibular Rehabilitation 4th Ed"**
  Donated by Susan J Herdman, PhD, FAPTA and FA Davis
- Marcy Stalvey won **VHI exercise Software**
  Donated by John E. Beaulieu, PhD., President/CEO, Visual Health Information
- Brooke Klatt, Denise Powell, Anne Gould-Ruete, Sara MacDowell each won **Neuronotes: Clinical Pocket Guide**, Donated by F.A. Davis Company
- Diane Wrisley won a Subscription to the **King-Devick Test App**
  Donated by King-Devick test
- Debbie Struiksma won **Balance Function Assessment and Management**
  Donated by Neil Shepard, with Gary Jacobson and Plural Publishing, Inc.
- Sue Whitney won **PhysioTools, Ltd Vestibular and Balance Exercise DVD Voucher**
  Donated by Kenda Fuller and Nora Musgrove, PhysioTools Ltd
- Melissa Bloom, Elizabeth Dannenbaum each won a **YEAR MEMBERSHIPS(120$) TO VEDA**,
  Donated by Matthew Hashbeck, VEDA
- Victoria Wrightson won a **Subscription to Journal of Vestibular Research** one year on-line membership, Donated by Kairi Look, Daphne Watrin, IOS Press