



Policy: CMP 202305 Initial Effective Date: 03/23/2023

SUBJECT: Eustachian Tube Dilation Annual Review Date: 04/26/2024

**Last Revised Date:** 04/26/2024

Prior approval is required for all procedure codes listed in this Corporate Medical Policy. Some or all procedure codes listed in this Corporate Medical Policy may be considered experimental/investigational.

**Definition: Balloon dilation of the eustachian tube (BDET)** The eustachian balloon is guided through the nasal passageway until it reaches the eustachian tube. The balloon is then inserted into the eustachian tube and inflated to dilate the dysfunctional or inflamed eustachian tube cartilage. When patency is restored, the balloon is deflated and removed from the eustachian tube. In the case that both eustachian tubes are affected, the procedure may be performed bilaterally.

### **Medical Necessity**

The Company considers balloon dilation of the eustachian tube (BDET) medically necessary for the treatment eustachian tube dysfunction, once per lifetime, and eligible for reimbursement providing that *all* of the following criteria are met:

- Age 18 years or older
- Eustachian tube dysfunction refractory to conservative conventional medical therapy.
- Minimum four weeks of a nasal steroid spray
- Long-term ETD ≥ three months with exam findings of significant tympanic membrane retraction or chronic fluid, and prior evaluation with nasal endoscopy otoscopy, audiometry, and nasal endoscopy.
- Prior to BETD, two abnormal tympanograms (Type B or C)
- Patient has a history of tympanostomy tube placement, and symptoms of eustachian tube obstruction improvement while tubes were patent/free of obstruction.
- Absence of a co-morbid condition that would be contraindicated for balloon dilation including but not limited to:
  - Carotid abnormalities (skull)
  - Nasopharyngeal or skull base neoplasm
  - Untreated allergic rhinities, rhinosinusitis
  - Untreated laryngopharyngeal reflux
  - A physician or trained technologist conducts procedure.

The Company considers balloon eustachian tube dilation (BDET) for the treatment eustachian tube dysfunction **investigational and experimental** for the following :

After initially successful BDET

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- After unsuccessful BDET
- With tympanoplasty or other middle ear surgery
- MMO considers trans-tympanic balloon dilatation of the eustachian tube experimental for the treatment of chronic ear disease because the effectiveness of this approach has not been established.

**Frequency limitations:** The frequency of eustachian tube dilation is limited to one procedure per lifetime for ages 18 and over by an ear, nose, and throat physician or trained technologist. For patients with deformities of the eustachian tube with conditions refractory to the initial one per lifetime BDET is considered **not medically necessary** and **not** eligible for reimbursement.

**Notes:** The Company considers balloon eustachian tube dilation (BDET) for treatment of clinical conditions not listed above **Not Medically Necessary** and **not** eligible for reimbursement.

Benefits requiring prior authorization services are subject to each specific benefit plan.

### **Documentation Requirements:**

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, or procedure, supply, product, or accommodation performed or furnished regardless of how the service, or procedure, supply, product, or accommodation was coded by the Provider.

Approval or clearance by the U.S. Food and Drug Administration alone is not a basis for coverage.

Coverage may differ for Medicare Advantage plan members; please see any applicable national and/or local coverage determinations for details. This information may be available at the Centers for Medicare & Medicaid Services (CMS) website.

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Applicable Code(s):	
CPT:	30999,69705, 69706, 69799
HCPCS:	
ICD10 Procedure Codes:	
10210110ccuire coues.	

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