MEDICAL MUTUAL

Medical Policy

Policy:	**202305**	**Effective Date:**	**01/13/2026**
SUBJECT:	**Eustachian Tube Dilation**	**Annual Review Date:**	**12/22/2025**
		Last Revised Date:	**12/22/2025**

Prior approval is required for some or 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) is a minimally invasive, transnasal procedure designed to treat eustachian tube dysfunction (ETD) by expanding and stretching the eustachian tube. During the procedure, a balloon catheter is inserted through the nasal passageway and guided to the eustachian tube. Once correctly positioned, the balloon is inflated to dilate the inflamed or obstructed eustachian tube cartilage. After patency is restored, the balloon is deflated and removed. If both eustachian tubes are affected, the procedure may be performed bilaterally.

Medical Necessity: The Company considers balloon dilation of the eustachian tube (BDET) for the treatment eustachian tube dysfunction (ETD) **medically necessary** and eligible for reimbursement providing that ***all*** of the following medical criteria are met:

- Age 18 years or older; and
- ETD refractory to conservative conventional medical therapy; and
- Minimum four weeks of a nasal steroid spray; and
- Long-term ETD (at least three months) with exam findings of significant tympanic membrane retraction or chronic fluid, and prior evaluation with otoscopy, audiometry, and nasal endoscopy; and
- Prior to BDET, two abnormal tympanograms (Type B or C); and
- If patient has a history of tympanostomy tube placement, symptoms of obstructive ETD improved while tubes were patent/free of obstruction; and
- A physician or trained technologist will conduct procedure; and
- Absence of a comorbid condition that would be contraindicated for balloon dilation including but not limited to the following:

    - Carotid abnormalities (skull); or
    - Nasopharyngeal or skull base neoplasm; or
    - Untreated allergic rhinitis, rhinosinusitis; or
    - Untreated laryngopharyngeal reflux.

The Company considers BDET for treatment eustachian tube dysfunction for the following to be **investigational** and **not** eligible for reimbursement:

- After initially successful BDET.
- After unsuccessful BDET.
- With tympanoplasty or other middle ear surgery.
- Trans-tympanic balloon dilation of the eustachian tube for the treatment of chronic ear disease.

Frequency limitations: The frequency of eustachian tube dilation is limited to one procedure per lifetime.

NOTE: The Company considers BDET that does not meet the medical criteria above to be **not standard of care** 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.

Sources of Information:

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Applicable Code(s):	
CPT:	**30999,69705, 69706, 69799**
HCPCS:	
ICD10 Procedure Codes:	