

**HYPERHIDROSIS**

Effective Date: August 20, 2018

Review Dates: 08/02, 8/03, 7/04, 7/05, 4/06, 4/07,  
10/07, 4/08, 4/09, 4/10, 4/11, 4/12, 4/13, 5/14, 5/15,  
5/16, 5/17, 5/18

Date Of Origin: August 28, 2002

Status: Current

**Summary of Changes**

Clarifications:

- 

Deletions:

- 

Additions:

- Pg. 1-2, Section I, C, criteria for the coverage of sympathectomy.
- Pg. 2, Section I, E, 6, criteria updated to reflect sympathectomy is not covered if plantar hyperhidrosis is the only indication.

**I. POLICY/CRITERIA**

Priority Health covers treatment of intractable, disabling primary hyperhidrosis for the indications described below.

- A. Treatment with Botulinum\* Toxin A or B or tumescent liposuction may be medically necessary for the treatment of primary axillary hyperhidrosis when the condition is refractory to conventional medical treatment (see section A, 1 and 2), including an attempt at both topical and systemic pharmacotherapy (unless clinically contraindicated) and both (1) and (2) below are present:
1. The condition is significantly interfering with the patient's ability to perform age-appropriate activities of daily living; *and*
  2. The condition is causing persistent or chronic cutaneous conditions such as skin maceration, dermatitis, fungal infections and secondary microbial conditions.

\*Botox treatment requires prior authorization.

- B. Treatment of primary hyperhidrosis with iontophoresis (electrophoresis, Drionic device) is considered experimental/investigational and is not a covered benefit.
- C. Sympathectomy is a covered benefit only when all of the following criteria are met:

1. Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash.
  2. The patient is unresponsive or unable to tolerate prescribed pharmacotherapy, such as anticholinergics, beta-blockers, or benzodiazepines.
  3. Skin maceration with secondary infections or significant functional impairment which disrupts an individual's professional and/or social life
- D. Surgical treatment of compensatory hyperhidrosis (the most common side effect of open or endoscopic sympathectomy) is not a covered benefit.
- E. The following treatments are not a covered benefit because they have not been proven to be effective for this indication:
1. Psychotherapy
  2. Hypnosis
  3. Laser treatment (including subdermal Nd-YAG laser)
  4. Microwave therapy
  5. Percutaneous thoracic phenol sympathectomy
  6. Sympathectomy where plantar hyperhidrosis is the only indication
- F. Alternative therapy methods including homeopathy, massage\*\*, acupuncture\*\* and phytotherapeutic drugs are not covered benefits.

*\*\*Note: Acupuncture and massage therapy may be covered with a rider for some commercial plans.*

## II. MEDICAL NECESSITY REVIEW

Required     Not Required \*except for Botox treatment     Not Applicable

## III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*

- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID/HEALTHY MICHIGAN PLAN:** *For Medicaid/Healthy Michigan plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945\\_42542\\_42543\\_42546\\_42551-159815--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html). If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945\\_5100-87572--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.*

#### IV. DESCRIPTION

##### Background:

Sweating is a natural phenomenon necessary for the regulation of an individual's body temperature. Hyperhidrosis, or excessive sweating, is a medical condition that is defined as sweating beyond what is necessary to maintain thermal regulation.

Hyperhidrosis is classified as primary or secondary, depending on its cause or origin. Primary hyperhidrosis, also known as essential or idiopathic hyperhidrosis, is caused by an overactive sympathetic nervous system. It can lead to intractable and profuse sweating in several locations of the body, including palms (hands), axillae (armpits), and plantar (feet). Secondary hyperhidrosis is the result of an underlying condition, such as Parkinson's disease, hyperthyroidism, diabetes mellitus, hyperpituitarism, pyrexia, hypoglycemia, or menopause. Secondary hyperhidrosis usually affects the whole body.

Regardless of the type or cause of hyperhidrosis, severe palmar hyperhidrosis can disrupt professional and social life and may lead to emotional problems. In the case of secondary hyperhidrosis, treatment of the underlying condition should first be attempted. In patients with disabling primary hyperhidrosis, a variety of treatment methods have been used.

The simplest method to control or reduce profuse sweating is the application of topical agents, such as aluminum chloride or other extra-strength chemical antiperspirants. Usually recommended as the first therapeutic measure, topical antiperspirants are effective in cases with light to moderate hyperhidrosis but have to be repeated regularly. Oral prescription medications commonly used include: anticholinergics, beta-blockers, and benzodiazepines.

Iontophoresis or electrophoresis can be tried if antiperspirants are not effective. Iontophoresis uses electric current to enhance drug penetration through the stratum corneum, the principal barrier to percutaneous absorption. Iontophoresis has been reported to provide temporary relief in mild cases of primary hyperhidrosis of the hands and feet. The procedure has to be repeated regularly, initially in 20-minute sessions several times a week, gradually stretching out the interval between treatments to 1-2 weeks; however, treatments must be maintained indefinitely to control the symptoms of mild hyperhidrosis. The results vary: many find the electric current uncomfortable, the treatment expensive, time consuming, and the results not lasting long enough. The Drionic device (General Medical Co., Los Angeles, California) is an iontophoretic device that can be purchased for home use.

Botulinum toxin type A (Botox) has been found to inhibit the release of acetylcholine not only at the neuromuscular junction, but also in postganglionic sympathetic fibers to sweat gland. There is some evidence from a limited number of small, short-term, randomized controlled trials that BTX-A can reduce the severity of primary axillary or palmar hyperhidrosis for several months, with only minor adverse effects. Several, very small, uncontrolled studies also suggest that BTX-A may be effective in relieving gustatory hyperhidrosis. Data regarding the efficacy of BTX-A for other types of hyperhidrosis are lacking, and long-term efficacy and safety, as well as patient selection criteria, have not been adequately determined. BTX-A (Botox®, Allergan Inc.) has been approved by the FDA for treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents. BTX-B (Myobloc®/Neurobloc®, Solstice Neurosciences Inc.) for the treatment of hyperhidrosis is an off-label use (FDA, 2005).

In severe cases of intractable, disabling primary hyperhidrosis, surgical intervention has been utilized. The principle of sympathectomy is to interrupt the nerve tracks and nodes that transmit the signals to the sweat glands. Whether performed open or endoscopically, the most common side effect of surgery is compensatory hyperhidrosis characterized by a moderate increase in sweating in other parts of the body. A rare side effect is "gustatory sweating", a condition that leads to the sensation of sweating when eating.

Surgical removal of sweat glands has been shown to be only effective in the treatment of axillary hyperhidrosis, and may leave significant scarring. For a person suffering from primary hyperhidrosis, this approach is usually only a partial solution to the problem, especially since the most annoying areas usually are the hands.

Poor results have been reported with the use of psychotherapy and hypnosis. Psychological problems are in most cases a consequence of hyperhidrosis, not the cause. Hence, psychiatric or psychopharmacologic therapy cannot cure this disorder; at most it may help the patient to accept living with the problem.

Alternative medicine interventions, including homeopathy, massage, acupuncture and phytotherapeutic drugs, have not been proven effective.

For complete overview of standard treatment algorithms please refer to The International Hyperhidrosis Society at the following website: [www.sweathelp.org](http://www.sweathelp.org)

## V. CODING INFORMATION

**ICD-10 Codes** that apply to this policy:

L74.510 Primary focal hyperhidrosis, axilla  
L74.511 Primary focal hyperhidrosis, face  
L74.512 Primary focal hyperhidrosis, palms  
L74.513 Primary focal hyperhidrosis, soles  
L74.519 Primary focal hyperhidrosis, unspecified  
L74.52 Secondary focal hyperhidrosis

R61 Generalized hyperhidrosis

**CPT/HCPCS Codes:**

*Surgical and Medical procedures billed with the above diagnoses include but are not limited to:*

64650 Chemodenervation of eccrine glands; both axillae  
64653 Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day  
  
15877 Suction assisted lipectomy; trunk  
15878 Suction assisted lipectomy; upper extremity  
15879 Suction assisted lipectomy; lower extremity  
  
32664 Thoracoscopy, surgical; with thoracic sympathectomy  
64804 Sympathectomy, cervicothoracic  
64809 Sympathectomy, thoracolumbar  
  
97033 Application of a modality to one or more areas; iontophoresis, each 15 minutes

Other Procedures:

E1399 Durable medical equipment, miscellaneous for home iontophoresis unit  
(*Explanatory notes must accompany claim*) *Not covered for Medicaid*

Prior Authorization required:

J0585 Injection, onabotulinum toxin A, 1 unit Botulinum toxin type A, per unit  
J0586 Injection, abobotulinum toxin A, 5 units Injection, abobotulinum toxin A, 5 units  
J0587 Injection, rimabotulinum toxin B, 100 units Botulinum toxin type B, per 100 units  
J0588 Injection, incobotulinum toxin A, 1 unit

Not Covered

- 17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
- 17111 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
- 64999 Unlisted procedure, nervous system (when billed for phenol sympathectomy; Explanatory notes must accompany claims billed with unlisted codes)
- 90832 Psychotherapy, 30 minutes with patient and/or family member
- 90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90834 Psychotherapy, 45 minutes with patient and/or family member
- 90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90837 Psychotherapy, 60 minutes with patient and/or family member
- 90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90880 Hypnotherapy
- 97024 Application of a modality to 1 or more areas; diathermy (eg, microwave)
- 97813 Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
- 97810 Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
- 97811 Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
- 97814 Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

**VI. REFERENCES:**

1. *Hyperhidrosis (Hyperhidrosis)* Clinical Policy Bulletin Number 0504. Aetna Inc., @ [http://www.aetna.com/cpb/medical/data/500\\_599/0504.html](http://www.aetna.com/cpb/medical/data/500_599/0504.html) (Retrieved August 9, 2013, March 16, 2015, March 4, 2016, & April 5, 2017).
2. *Botulinum Toxin Treatment for Hyperhidrosis*, HAYES, Inc. February 2002
3. Licht PB, Pilegaard HK. Severity of compensatory sweating after thoracoscopic sympathectomy. *Ann Thorac Surg.* 2004;78(2):427-431.
4. Eisenach JH, Atkinson JL, Fealey RD. Hyperhidrosis: Evolving therapies for a well-established phenomenon. *Mayo Clin Proc.* 2005;80(5):657-666.

5. Dressler D, Saberi FA, Benecke R. Botulinum toxin type B for treatment of axillar hyperhidrosis. *J Neurol*. 2002;249(12):1729-1732.
6. Baumann LS, Helam ML. Botulinum toxin-B and the management of hyperhidrosis. *Dermatology*. 2004;22(1):60-65.
7. NHS Institute for Innovation and Improvement, Clinical Knowledge Summaries Service (CKS). Hyperhidrosis - management. CKS Clinical Knowledge Summaries. Newcastle upon Tyne, UK; Sowerby Centre for Health Informatics at Newcastle (SCHIN); revised March 2009.
8. Licht PB, Ladegaard L, Pilegaard HK. Thoracoscopic sympathectomy for isolated facial blushing. *Ann Thorac Surg*. 2006;81(5):1863-1866.
9. Glaser DA. The use of botulinum toxins to treat hyperhidrosis and gustatory sweating syndrome. *Neurotox Res*. 2006;9(2-3):173-177.
10. International Hyperhidrosis Society (IHS). About hyperhidrosis. Clinical Guidelines. May 2014. @ <http://www.sweathelp.org/treatments-hcp/clinical-guidelines.html> (Retrieved April 5, 2017).
11. Smith CC. Idiopathic hyperhidrosis. UpToDate [online serial]. Waltham, MA: UpToDate; October 2008.
12. Talarico-Filho S, Mendonca DO Nascimento M, Sperandeo DE Macedo F, DE Sanctis Pecora C. A double-blind, randomized, comparative study of two type A botulinum toxins in the treatment of primary axillary hyperhidrosis. *Dermatol Surg*. 2007;33(1 Spec No.):S44-S50.
13. Glogau RG. Topically applied botulinum toxin type A for the treatment of primary axillary hyperhidrosis: Results of a randomized, blinded, vehicle-controlled study. *Dermatol Surg*. 2007;33(1 Spec No.):S76-S80.
14. Lowe NJ, Glaser DA, Eadie N, et al; North American Botox in Primary Axillary Hyperhidrosis Clinical Study Group. Botulinum toxin type A in the treatment of primary axillary hyperhidrosis: A 52-week multicenter double-blind, randomized, placebo-controlled study of efficacy and safety. *J Am Acad Dermatol*. 2007;56(4):604-611.
15. Malmivaara A, Kuukasjarvi P, Autti-Ramo I, et al. Effectiveness and safety of endoscopic thoracic sympathectomy for excessive sweating and facial blushing: A systematic review. *Int J Technol Assess Health Care*. 2007;23(91):54-62.
16. Solish N, Bertucci V, Dansereau A, et al.; Canadian Hyperhidrosis Advisory Committee. A comprehensive approach to the recognition, diagnosis, and severity-based treatment of focal hyperhidrosis: Recommendations of the Canadian Hyperhidrosis Advisory Committee. *Dermatol Surg*. 2007;33(8):908-923.
17. New Zealand Dermatology Society Inc (NZDS). Hyperhidrosis. DermNet NZ [website]. Auckland, NZ: NZDS; 2009. Available at: <http://www.dermnet.org.nz/>. Accessed August 21, 2009.
18. British Association of Dermatologists (BAD). Hyperhidrosis support group [website]. London, UK: BAD; 2009. Available at: <http://www.hyperhidrosisuk.org/>. Accessed August 21, 2009.

19. Seo SH, Jang BS, Oh CK, et al. Tumescant superficial liposuction with curettage for treatment of axillary bromhidrosis. *J Eur Acad Dermatol Venereol.* 2008;22(1):30-35.
20. Wollina U, Köstler E, Schönlebe J, Haroske G. Tumescant suction curettage versus minimal skin resection with subcutaneous curettage of sweat glands in axillary hyperhidrosis. *Dermatol Surg.* 2008;34(5):709-716.
21. Goldman A, Wollina U. Subdermal Nd-YAG laser for axillary hyperhidrosis. *Dermatol Surg.* 2008;34(6):756-762.
22. Commons GW, Lim AF. Treatment of axillary hyperhidrosis/bromidrosis using VASER ultrasound. *Aesthetic Plast Surg.* 2009;33(3):312-323.
23. Kim WO, Kil HK, Yoon KB, et al. Influence of T3 or T4 sympatricotomy for palmar hyperhidrosis. *Am J Surg.* 2010;199(2):166-169.
24. Bejarano B, Manrique M. Thoracoscopic sympatricotomy: A literature review. *Neurocirugia (Astur).* 2010;21(1):5-13.
25. Streker M, Reuther T, Verst S, Kerscher M. Axillary hyperhidrosis -- efficacy and tolerability of an aluminum chloride antiperspirant. Prospective evaluation on 20 patients with idiopathic axillary hyperhidrosis. *Hautarzt.* 2010;61(2):139-144.
26. Hoorens I, Ongenae K. Primary focal hyperhidrosis: Current treatment options and a step-by-step approach. *J Eur Acad Dermatol Venereol.* 2012;26(1):1-8.
27. Cerfolio RJ, De Campos JR, Bryant AS, et al. The Society of Thoracic Surgeons expert consensus for the surgical treatment of hyperhidrosis. *Ann Thorac Surg.* 2011;91(5):1642-1648.
28. Walling HW. Systemic therapy for primary hyperhidrosis: A retrospective study of 59 patients treated with glycopyrrolate or clonidine. *J Am Acad Dermatol.* 2012;66(3):387-392.
29. Paller AS, Shah PR, Silverio AM, et al. Oral glycopyrrolate as second-line treatment for primary pediatric hyperhidrosis. *J Am Acad Dermatol.* 2012;67(5):918-923.
30. Wolosker N, de Campos JR, Kauffman P, Puech-Leão P. A randomized placebo-controlled trial of oxybutynin for the initial treatment of palmar and axillary hyperhidrosis. *J Vasc Surg.* 2012;55(6):1696-1700.
31. Wang YC, Wei SH, Sun MH, Lin CW. A new mode of percutaneous upper thoracic phenol sympatricolysis: Report of 50 cases. *Neurosurgery.* 2001;49(3):628-634.
32. Kao TH, Pan HC, Sun MH, et al. Upper thoracic sympatricotomy for axillary osmidrosis or bromidrosis. *J Clin Neurosci.* 2004;11(7):719-722.
33. Letada PR, Landers JT, Uebelhoer NS, Shumaker PR. Treatment of focal axillary hyperhidrosis using a long-pulsed Nd:YAG 1064 nm laser at hair reduction settings. *J Drugs Dermatol.* 2012; 11(1):59-63.
34. Bechara FG, Georgas D, Sand M, et al. Effects of a long-pulsed 800-nm diode laser on axillary hyperhidrosis: A randomized controlled half-side comparison study. *Dermatol Surg.* 2012;38(5):736-740.



35. Hong HC, Lupin M, O'Shaughnessy KF. Clinical evaluation of a microwave device for treating axillary hyperhidrosis. *Dermatol Surg.* 2012;38(5):728-735.
36. Glaser DA, Coleman WP 3rd, Fan LK, et al. A randomized, blinded clinical evaluation of a novel microwave device for treating axillary hyperhidrosis: The dermatologic reduction in underarm perspiration study. *Dermatol Surg.* 2012;38(2):185-191.
37. *Hyperhidrosis Treatments*, Medical Coverage Policy 0037, Cigna.  
@ [https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm\\_0037\\_coveragepositioncriteria\\_endoscopic\\_sympathectomy\\_for\\_hyperhidrosis.pdf](https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0037_coveragepositioncriteria_endoscopic_sympathectomy_for_hyperhidrosis.pdf) (Retrieved April 5, 2017; March 28, 2018).
38. *Hyperhidrosis Treatments*, Medical Coverage Policy HGO-0451-009, Humana,  
@ [http://apps.humana.com/tad/tad\\_new/Search.aspx?criteria=Hyperhidrosis&searchtype=freetext&policyType=both](http://apps.humana.com/tad/tad_new/Search.aspx?criteria=Hyperhidrosis&searchtype=freetext&policyType=both) (Retrieved April 5, 2017; March 28, 2018).
39. *Treatment of Hyperhidrosis, Excluding Botulinum*, Medical Policy, Blue Cross Blue Shield of Michigan,  
@ <http://www.bcbsm.com/mprApp/MedicalPolicyDocument?fileId=2102022> (Retrieved April 5, 2017).  
<https://www.bcbsm.com/mprApp/MedicalPolicyDocument?fileId=2120119> (Retrieved March 28, 2018).
40. *Endoscopic Thoracic Sympathectomy for the Treatment of Hyperhidrosis*, Medical Policy, Blue Cross Blue Shield of Michigan,  
@ <http://www.bcbsm.com/mprApp/MedicalPolicyDocument?fileId=92089> (Retrieved April 5, 2017; March 28, 2018).
41. *Botulinum Toxins*, Medical Policy, Blue Cross Blue Shield of Michigan,  
@ <http://www.bcbsm.com/mprApp/MedicalPolicyDocument?fileId=2054817> (Retrieved April 5, 2017; March 28, 2018).

**AMA CPT Copyright Statement:**

All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

---

*This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.*

*Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.*

*The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.*