Clinical Policy: Hyperhidrosis Treatments

Reference Number: CP.MP.62
Date of Last Revision: 01/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Hyperhidrosis is defined as excessive sweating beyond a level required to maintain normal body temperature in response to heat exposure or exercise.

Refer to CP.PHAR.230 AbobotulinumtoxinA (Dysport)
Refer to CP.PHAR.232 OnabotulinumtoxinA (Botox)
Refer to CP.PMN.177 Qbrexza (glycopyrronium) for requests for glycopyrronium

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that treatment with iontophoresis (electrophoresis, Drionic device) is **medically necessary** when *all* of the following criteria are met:
- A. Diagnosis of primary hyperhidrosis;
- B. Development of medical complications, such as skin maceration with secondary skin infections; *or* has a significant constant disruption of professional and/or social life (e.g., recurrent changing of clothes, affecting job/social function, etc.) which has occurred because of excessive sweating;
- C. Unresponsive or unable to tolerate at least one of the pharmacotherapies prescribed for excessive sweating (e.g., anticholinergics, beta-blockers, or benzodiazepines);
- D. Failed a 6-month trial of conservative management including the adherent application of aluminum chloride hexahydrate [Drysol by prescription] or topical agents have resulted in a severe rash;
- E. Has none of the following contraindications:
  1. Cardiac pacemaker;
  2. Cardiac arrhythmias;
  3. Pregnancy (hyperhidrosis often improves during pregnancy);
  4. Metal implants, depending on size and position (may divert the electric current);
  5. Cracked skin near the treatment area.

II. It is the policy of health plans affiliated with Centene Corporation® that endoscopic thoracic sympathectomy (ETS) for palmar or palmar and axillary hyperhidrosis is **medically necessary** when *all* of the following criteria are met:
- A. Meets all of the iontophoresis criteria in I.A-D;
- B. Has a resting heart rate ≥ 55 beats per minute;
- C. Hyperhidrosis symptoms started at an early age (usually < 16 years), and surgery is requested for a young member (usually <25 years of age);
- D. Body mass index <28;
- E. Reports no sweating during sleep;
- F. The member is relatively healthy with no significant comorbidities;
- G. Has persistent and severe primary hyperhidrosis;

H. Has failed one of the following:
   1. Iontophoresis;
   2. Trial of botulinum toxin for predominantly axillary hyperhidrosis.

III. It is the policy of health plans affiliated with Centene Corporation® that surgical excision of axillary sweat glands for axillary hyperhidrosis are **medically necessary** when *all* of the following criteria are met:
A. Meets all of the iontophoresis criteria in I.A-D;
B. Has persistent and severe primary hyperhidrosis;
C. Has failed one of the following:
   1. Iontophoresis;
   2. Trial of botulinum toxin.

Note: The normal line of medical therapy is:
1. Drysol, then botox or topical glycopyrronium for axillary hyperhidrosis
2. Drysol, then iontophoresis for palmoplantar hyperhidrosis
3. Other treatments are third-line therapies (iontophoresis and surgery for axillary hyperhidrosis, and Botox and surgery for palmoplantar hyperhidrosis).

IV. There is insufficient evidence in published peer-reviewed literature to support all other treatments for hyperhidrosis, including, but not limited to, microwave therapy, or liposuction as the sole method of removing axillary sweat glands.

Background

Hyperhidrosis can be classified as either primary or secondary. Primary focal hyperhidrosis is idiopathic in nature and is defined as excessive sweating induced by sympathetic hyperactivity in selected areas that is not associated with an underlying disease process. The most common locations are underarms (axillary hyperhidrosis), hands (palmar hyperhidrosis), and feet (plantar hyperhidrosis). Primary focal hyperhidrosis is a condition that is characterized by visible, excessive sweating of at least 6 months' duration without apparent cause. Hyperhidrosis can ruin clothing, produce emotional distress, and lead to occupational disability.

Secondary hyperhidrosis can result from a variety of drugs, such as tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), or underlying diseases/conditions, such as febrile diseases, diabetes mellitus, or menopause. Secondary hyperhidrosis is usually generalized or craniofacial sweating. Secondary gustatory hyperhidrosis is excessive sweating on ingesting highly spiced foods. This trigeminovascular reflex typically occurs symmetrically on scalp or face and predominately over forehead, lips, and nose. Secondary facial gustatory sweating, in contrast, is usually asymmetrical and occurs independently of the nature of the ingested food. This phenomenon frequently occurs after injury or surgery in the region of the parotid gland.

A variety of therapies have been investigated for primary hyperhidrosis, including topical therapy with aluminum chloride, iontophoresis, intradermal injections of botulinum toxin type A, endoscopic transthoracic sympathectomy, and surgical excision of axillary sweat glands. Thoracic sympathectomy is an invasive procedure intended to arrest the symptoms of hyperhidrosis. Treatment of secondary hyperhidrosis focuses on the treatment of the underlying

cause, such as discontinuing certain drugs or hormone replacement therapy as a treatment of menopausal symptoms.

Microwave energy has been proposed for the treatment of primary axillary hyperhidrosis. The miraDry System (Mirimar Labs, Inc) is an FDA approved device indicated for treatment of primary axillary hyperhidrosis. It is not indicated for treating hyperhidrosis related to other body areas or generalized hyperhidrosis. There is insufficient evidence in published peer-reviewed literature to support the safety and efficacy of microwave energy for the treatment of primary axillary hyperhidrosis. Most of the studies are limited by small sample size with data on long-term health outcomes lacking.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
11450	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair
11451	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair
15877*	Suction assisted lipectomy; trunk
15878*	Suction assisted lipectomy; upper extremity
32664	Thoracoscopy, surgical; with thoracic sympathectomy
64802 – 64823	Sympathectomy, sympathetic nerves
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes

* Insufficient evidence in published peer-reviewed literature to support suction assisted liposuction as the sole method of removing axillary sweat glands.

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
L74.510-L74.519	Primary focal hyperhidrosis
L74.52	Secondary hyperhidrosis
R61	Generalized hyperhidrosis

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy Developed Specialist review	04/13	05/13
Removed all surgical treatments except ETS and excision of sweat glands Updated coding implications	04/14	05/14
Removed Botox and Dysport from policy, refer to CP.PHAR.09 Botulinum Toxins	04/15	04/15
Policy converted to new template References reviewed and updated	04/16	04/16
Added microwave therapy for treatment of hyperhidrosis as investigational. Specified in I.A. and II.B. that diagnosis must be primary hyperhidrosis. References reviewed and updated. ICD 10 codes added.	04/17	04/17
Changed I.B from "job/social promotion" to "job/social function." References reviewed and updated.	02/18	02/18
Separated criteria for ETS and removal of axillary sweat glands, and specified that they meet criteria for iontophoresis A-D. For ETS, added criteria that member heart rate is ≥ 55 beats per minute, symptoms started before 16 years of age, and surgery is on a member less than 25 years of age, that there be no significant comorbidities, that there is no night sweating, and BMI < 28, per 2011 guidelines.	06/18	06/18
Added topical glycopyrronium to normal line of medical therapy for axillary hyperhidrosis, in the note under III. References reviewed and updated.	01/19	02/19
Removed informational codes for chemical denervation of sweat glands: 64560, 64563. Added codes 11450 and 11451.	11/19	
Section IV: Added liposuction as the sole method of removing axillary sweat glands as investigational. Specialist reviewed.	12/19	01/20
Combined criteria points in II. H. and III. C to read "failed one of the following: 1. Iontophoresis or 2. Trial of botulinum toxin." References reviewed and updated. Replaced "members" with "members/enrollees" in all instances.	12/20	01/21
Annual review. References reviewed and updated. Reviewed by specialist. Changed "Last Review Date" in the header to "Date of Last Revision" and "Date" in revision log to "Revision Date". "Experimental/investigational" verbiage replaced in policy statement and background with descriptive language. Updated reference to CP.PHAR.09 to CP.PHAR.230 and CP.PHAR.232 as well as CP.PMN.117 to CP.PMN.177.	01/22	1/22

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of

physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.