



Hyperhidrosis Treatment

I. Policy

University Health Alliance (UHA) will reimburse for thoracic sympathectomy for hyperhidrosis when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

- A. Treatment of patients with severe primary focal hyperhidrosis (hyperhidrosis disease severity scale 3 or 4 – scale cited below) is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met:
1. The patient has a documented history of debilitating hyperhidrosis that prevents him or her from performing essential activities of daily living and employment or has any of the following medical complications:
 - a. Acrocyanosis of the hands; or
 - b. History of recurrent skin maceration with bacterial or fungal infections; or
 - c. History of recurrent secondary infections; or
 - d. History of persistent eczematous dermatitis in spite of medical treatments with topical dermatological or systemic anticholinergic agents.
 2. Specific treatments for the following primary focal hyperhidrosis regions listed below are covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the criteria listed above are met as well as any of the following specific criteria relevant to a particular area:
 - a. Axillary and palmar regions:
 - i. Aluminum chloride 20% solution;
 - ii. Botulinum toxin for severe primary axillary hyperhidrosis that is inadequately managed with topical agents in patients 18 years and older;
 - iii. Endoscopic transthoracic sympathectomy (ETS) (and surgical excision of axillary sweat glands for Axillary region), if conservative treatment above (individually and in combination) has failed.
 - b. Plantar region:
 - i. Aluminum chloride 20% solution
 - c. Craniofacial region:
 - i. Aluminum chloride 20% solution;
 - ii. Endoscopic transthoracic sympathectomy (ETS) if conservative treatment has failed.
 3. The following treatments for severe secondary gustatory hyperhidrosis (hyperhidrosis disease severity scale 3 or 4) are covered (subject to Limitations/Exclusions and Administrative Guidelines):
 - a. Aluminum chloride 20% solution

- b. Surgical options (i.e., tympanic neurectomy) if conservative treatment has failed.
- 4. When indicated, the products must have been tried for a minimum of four weeks.
- B. Where hyperhidrosis is secondary to a primary medical condition, that primary condition should be identified and treated wherever possible.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation

III. Limitations

- A. Treatments for the primary focal hyperhidrosis regions listed below are not covered because they are not known to be effective in improving health outcomes:
 - 1. Axillary region:
 - a. Axillary liposuction;
 - b. Iontophoresis; and
 - c. Microwave treatment.
 - d. Radiofrequency ablation
 - 2. Palmar region:
 - a. Rimabotulinumtoxin B;
 - b. Iontophoresis;
 - c. Microwave treatment
 - d. Radiofrequency ablation.
 - 3. Plantar region:
 - a. Botulinum toxin;
 - b. Iontophoresis;
 - c. Lumbar sympathectomy
 - d. Microwave treatment.
 - e. Radiofrequency ablation
 - 4. Craniofacial region:
 - a. Botulinum toxin;
 - b. Iontophoresis; and
 - c. Microwave treatment.

- d. Radiofrequency ablation
- 5. Other treatments for severe secondary gustatory hyperhidrosis are not covered including, but not limited to botulinum toxin and iontophoresis.

IV. Administrative Guidelines

- A. Prior authorization is required.
- B. For the majority of patients, treatment of primary hyperhidrosis will not meet UHA's payment determination criteria for medical appropriateness based on the lack of an essential functional impairment or medical complications associated with the condition.
- C. Treatment of hyperhidrosis for cosmetic reasons is not a benefit of UHA plans and is therefore ineligible for coverage.
- D. If prior authorization is given for thoracoscopy with thoracic sympathectomy the approval will be limited to the ASC setting.
- E. In the hyperhidrosis disease severity scale referenced in this policy above, patients rate the severity of symptoms on a scale of 1 to 4:
 - 1. My underarm sweating is never noticeable and never interferes with my daily activities.
 - 2. My underarm sweating is tolerable but sometimes interferes with my daily activities.
 - 3. My underarm sweating is barely tolerable and frequently interferes with my daily activities.
 - 4. My underarm sweating is intolerable and always interferes with my daily activities.
- F. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

CPT Code	Description
32664	Thoracoscopy, surgical; with thoracic sympathectomy
64650	Chemodeneration of eccrine glands; both axillae
64653	Chemodeneration of eccrine glands; other area(s) (e.g., scalp, face, neck), per day
69676	Tympanic neurectomy

V. Policy History

Policy Number: MPP-0053-120301
Current Effective Date: 07/03/2019
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