Clinical Policy: Hyperhidrosis Treatments

Reference Number: LA.CP.MP.62 Coding Implications
Date of Last Revision: 2/25 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 the Louisiana Medicaid Preferred Drugs List, (PDL) and the LDH guidelines for coverage criteria for the medications referenced in this clinical policy

- *AbobotulinumtoxinA (Dysport®)*
- *OnabotulinumtoxinA (Botox®)*
- *Qbrexza (glycopyrronium)*

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections 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 six-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;
  4. Metal implants, depending on size and position (may divert the electric current);
  5. Epilepsy.

II. It is the policy of Louisiana Healthcare Connections 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. through I.E.;
- B. Has persistent and severe primary hyperhidrosis;
- C. Has failed one of the following:
  1. Iontophoresis;
  2. Trial of botulinum toxin.

III. It is the policy of Louisiana Healthcare Connections 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. through I.E.;
B. Member/enrollee 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/enrollee (usually < 25 years of age);
D. Body mass index < 28;
E. Reports no sweating during sleep;
F. Member/enrollee has no significant comorbidities;
G. Member/enrollee has persistent and severe primary hyperhidrosis;
H. Member/enrolle has failed one of the following:
    1. Iontophoresis;
    2. Trial of botulinum toxin for predominantly axillary hyperhidrosis;
I. Member/enrollee has been counseled on risks of procedure.

Note: The standard line of medical therapy is:

1. Drysol, then Botox or topical glycopyrronium for axillary hyperhidrosis;
2. Drysol, then iontophoresis for palmoplantar hyperhidrosis;
3. Third-line therapies such as iontophoresis and surgery for axillary hyperhidrosis, and Botox and surgery for palmoplantar hyperhidrosis.

IV. There is insufficient evidence in the 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.[1] 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.[2] 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 six months' duration without apparent cause. Hyperhidrosis can ruin clothing, produce emotional distress, and lead to occupational disability.[1]

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 the 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 (ETS), and surgical excision of axillary sweat glands.[1,3,4] ETS is an invasive procedure intended to arrest the symptoms of hyperhidrosis and involves interrupting the upper thoracic sympathetic chain through clipping, cauterization, or cutting.[1] ETS is considered a last resort due to potential serious, irreversible compensatory sweating (excessive sweating on large areas of the body or all over), as well as other effects, such as extreme hypotension, arrhythmia, and heat intolerance.[5] 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 a Food and Drug Administration (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. According to the National Institute for Health and Care Excellence (NICE), "Current evidence on the safety and efficacy of transcutaneous microwave ablation for severe primary axillary hyperhidrosis is inadequate in quantity and quality. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and audit or research. NICE encourages further research into transcutaneous microwave ablation for severe primary axillary hyperhidrosis and may update the guidance on publication of further evidence."[6]

Coding Implications

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NOTE: Coverage is subject to each requested code's inclusion on the corresponding LDH fee schedule. Non-covered codes are denoted (*) and are reviewed for Medical Necessity for members under 21 years of age on a per case basis.

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[1*]	Suction assisted lipectomy; trunk
15878[1*]	Suction assisted lipectomy; upper extremity
32664	Thoracoscopy, surgical; with thoracic sympathectomy
97024*[1]	Application of a modality to 1 or more areas; diathermy (eg, microwave)

CPT® Codes	Description
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes

[1]Insufficient evidence in published peer-reviewed literature to support suction assisted liposuction or diathermy as the sole method of removing axillary sweat glands.

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Converted corporate to local policy.	1/21/20		
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". Added “and may not support medical necessity” to coding implications. “Experimental/investigational” verbiage replaced in policy statement and background with descriptive language.	2/22		
Annual review. Updated Criteria II.B. to greater than 55 beats per minute. Removed “is relatively healthy” in criteria II.F. Background updated with no impact on criteria. ICD-10 codes removed. References reviewed and updated. References made to include LDH coverage criteira for medications described in the policy	4/23	5/26/23	
Annual review. Minor rewording of pharmacy policy title (in description). Changed order of criteria. Added criteria point III.I. regarding counseling on risks. Background updated with no clinical significance. Removed CPT codes 64802 through 64823. References reviewed and updated. Reviewed by external specialist.	02/24	4/29/24	
Added note regarding the normal line of medical therapy back into policy after erroneously removing during February 2024 annual policy review.	4/24	6/25/24	
Annual review. Updated criteria I.E.3. by removing (hyperhidrosis often improves pregnancy). Removed previous Criteria I.E.5. regarding cracked skin near the treatment area. Added epilepsy to Criteria I.E.5. Minor grammatical update in Criteria II. Updated Criteria II.A. to include through Criteria I.E. Minor grammatical update in Criteria III. Updated Criteria III.A. to include through Criteria I.E. Updated verbiage in Criteria III.B., Criteria III.F., Criteria III.G., Criteria III.H., and Criteria III.I. with no impact to criteria. Updated verbiage in Note section at the end of Criteria III. with no impact to criteria. Minor verbiage update in Criteria IV. Background updated with no impact to criteria. Added diathermy to notation at end of coding section regarding insufficient evidence in the peer-reviewed literature. References reviewed and updated.	02/25	4/28/25	5/29/25

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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. LHCC 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.

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