Clinical Policy: Hyperhidrosis Treatments

Reference Number: CP.MP.62
Date of Last Revision: 11/24

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.

Please refer to the following:

- *CP.PHAR.230 AbobotulinumtoxinA (Dysport)*
- *CP.PHAR.232 OnabotulinumtoxinA (Botox)*
- *CP.PMN.177 Glycopyrronium (Qbrexza)*

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 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 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. 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 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. 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

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 2023, 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
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 or diathermy as the sole method of removing axillary sweat glands.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy Developed. Specialist review.	04/13	05/13
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
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.	01/23	01/23
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.	01/24	01/24
Added note regarding the normal line of medical therapy back into policy after erroneously removing during January 2024 annual policy review.	03/24	03/24
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.	11/24	11/24

References

1. Smith CC, Pariser, D. Primary focal hyperhidrosis. UpToDate. www.uptodate.com. Published May 13, 2024. Accessed November 01, 2024
2. Glaser DA. The use of botulinum toxins to treat hyperhidrosis and gustatory sweating syndrome. *Neurotox Res*. 2006;9(2 to 3):173 to 177. doi:10.1007/BF03033936
3. 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 to 1648 doi:10.1016/j.athoracsur.2011.01.105

4. Eisenach JH, Atkinson JL, Fealey RD. Hyperhidrosis: evolving therapies for a well-established phenomenon [published correction appears in Mayo Clin Proc. 2005 Jun;80(6):828]. *Mayo Clin Proc*. 2005;80(5):657 to 666. doi:10.4065/80.5.657
5. International Hyperhidrosis Society. Endoscopic thoracic sympathectomy (ETS). https://www.sweathelp.org/hyperhidrosis-treatments/ets-surgery.html. Accessed October 31, 2024.
6. National Institute for Health and Care Excellence. Transcutaneous microwave ablation for severe primary axillary hyperhidrosis. Interventional procedures guidance [IPG601]. https://www.nice.org.uk/guidance/ipg601. Published December 20, 2017. Accessed November 04, 2024.
7. International Hyperhidrosis Society. Hyperhidrosis Treatment Overview. https://www.sweathelp.org/hyperhidrosis-treatments/treatment-overview.html. Accessed October 31, 2024.
8. Arora G, Kassir M, Patil A, et al. Treatment of Axillary hyperhidrosis. *J Cosmet Dermatol*. 2022;21(1):62-70. doi:10.1111/jocd.14378
9. Lakraj, AA, Moghimi N, Jabbari B. Hyperhidrosis: anatomy, pathophysiology and treatment with emphasis on the role of botulinum toxins. *Toxins (Basel)*. 2013;5(4):821 to 840. Published 2013 Apr 23. doi:10.3390/toxins5040821
10. Oakley A. Hyperhidrosis. DermNet NZ. https://dermnetnz.org/topics/hyperhidrosis. Updated July 2015. Accessed November 04, 2024.
11. Cole A, Oakley A. DermNet NZ. https://dermnetnz.org/topics/iontophoresis. Updated April 2015. Accessed November 01, 2024.
12. 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 to 191. doi:10.1111/j.1524-4725.2011.02250.x
13. Pariser DM, Hebert AA, Drew J, Quiring J, Gopalan R, Glaser DA. Topical Glycopyrronium Tosylate for the Treatment of Primary Axillary Hyperhidrosis: Patient Reported Outcomes from the ATMOS-1 and ATMOS-2 Phase III Randomized Controlled Trials. *Am J Clin Dermatol*. 2019;20(1):135 to 145. doi:10.1007/s40257-018-0395-0
14. Glaser DA, Hebert AA, Nast A, et al. Topical glycopyrronium tosylate for the treatment of primary axillary hyperhidrosis: Results from the ATMOS-1 and ATMOS-2 phase 3 randomized controlled trials. *J Am Acad Dermatol*. 2019;80(1):128 to 138.e2. doi:10.1016/j.jaad.2018.07.002
15. Sheikh NK, Dua A. Iontophoresis Analgesic Medications. In: *StatPearls*. Treasure Island (FL): StatPearls Publishing; July 31, 2023. Accessed November 3, 2023.
16. Vannucci F, Araújo JA. Thoracic sympathectomy for hyperhidrosis: from surgical indications to clinical results. *J Thorac Dis*. 2017;9(Suppl 3):S178 to S192. doi:10.21037/jtd.2017.04.04
17. Dunlap L, Clifton AV, Stephenson J, et al. Interventions for hyperhidrosis. *Cochrane Database of Syst Rev.* 2022(2). doi: 10.1002/14651858.CD015135
18. Hong HC, Lupin M, O'Shaughnessy KF. Clinical evaluation of a microwave device for treating axillary hyperhidrosis. *Dermatol Surg*. 2012;38(5):728 to 735. doi:10.1111/j.1524-4725.2012.02375.x
19. International Hyperhidrosis Society. Brella™ Sweat Control Patch™. https://www.sweathelp.org/hyperhidrosis-treatments/brella.html. Accessed October 31, 2024.

20. International Hyperhidrosis Society. Iontophoresis. https://www.sweathelp.org/treatments-hcp/iontophoresis.html. Accessed November 04, 2024.
21. Evidence Analysis Research Brief. Microwave therapy for management of hyperhidrosis. Hayes. www.hayesinc.com. Published April 19, 2022. Accessed November 04, 2024.
22. Hsu TH, Chen YT, Tu YK, Li CN. A systematic review of microwave-based therapy for axillary hyperhidrosis. *J Cosmet Laser Ther*. 2017;19(5):275 to 282. doi:10.1080/14764172.2017.1303168
23. International Hyperhidrosis Society. Sofdra™ Topical Gel for Primary Axillary Hyperhidrosis. https://www.sweathelp.org/hyperhidrosis-treatments/sofdra.html. Accessed November 04, 2024.

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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.