Clinical Policy: Hyperhidrosis Treatments

Reference Number: CP.MP.62 Coding Implications
Last Review Date: 02/18 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.09 Botulinum Toxins for requests for Botox or Dysport.

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. Member has developed 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. Is 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 it 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 and axillary hyperhidrosis and 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 above;
   B. Has persistent and severe primary hyperhidrosis;
   C. Has failed iontophoresis;
   D. Has failed a trial of botulinum toxin.

Note: The normal line of medical therapy is:
1. Drysol, then botox 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).

III. All other treatments for hyperhidrosis, including, but not limited to, microwave therapy, are considered **investigational and not medically necessary.**

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. The evidence supporting the safety and efficacy of microwave energy for the treatment of primary axillary hyperhidrosis is limited, thus it is considered investigational and not medically necessary. Most of the studies are limited by small sample size with data on long-term health outcomes lacking.

Coding Implications

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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
32664	Thoracoscopy, surgical; with thoracic sympathectomy
64650	Chemodenervation of eccrine glands; both axillae
64653	other area(s) (e.g., scalp, face, neck), per day
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

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	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

References

1. 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
2. Eisenach JH, Atkinson JL, Fealey RD. Hyperhidrosis: Evolving therapies for a well-established phenomenon. Mayo Clin Proc. 2005;80(5):657-666.
3. Glaser DA. The use of botulinum toxins to treat hyperhidrosis and gustatory sweating syndrome. Neurotox Res. 2006;9(2-3):173-177.

4. 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; 38:185
5. Hong HC, Lupin M, O'Shaughnessy KF. Clinical evaluation of a microwave device for treating axillary hyperhidrosis. Dermatol Surg 2012; 38:728.
6. Hsu TH, Chen YT, Tu YK, Li CN. A systematic review of microwave-based therapy for axillary hyperhidrosis. J Cosmet Laser Ther. 2017 Mar 10.
7. International Hyperhidrosis Society. Hyperhidrosis Treatment Overview. 2017. Available at: http://www.sweathelp.org/en/hyperhidrosis-treatments/treatment-overview.html.
8. Karpinski RHS. Surgical treatment of axillary hyperhidrosis treatment & management. In: Medscape Reference, Caputy G (Ed), 2012 Jan 31.
9. Lakraj, A.D; Moghimi, N; Jabbari, B. Hyperhidrosis: Anatomy, Pathophysiology and Treatment with Emphasis on the Role of Botulinum Toxins. Toxins 2013, 5, 821-840; doi:10.3390/toxins5040821.
10. New Zealand Dermatology Society Inc. Hyperhidrosis. DermNet NZ [website] Auckland, NZ: NZDS 2015. Available at: http://www.dermnetnz.org/hair-nails-sweat/hyperhidrosis.html.
11. New Zealand Dermatology Society Inc. Iontophoresis. DermNet NZ [website] Auckland, NZ: NZDS 2013. Available at: http://www.dermnetnz.org/procedures/iontophoresis.html.
12. Smith, CC. MD; Pariser, D. MD. Primary focal hyperhidrosis. In: UpToDate, Dellavalle RP, Dahl MV (Ed), UpToDate, Waltham, MA. Accessed 2/9/18.

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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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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, 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, 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.