Status
Active

Medical and Behavioral Health Policy
Section: Medicine
Policy Number: II-55
Effective Date: 09/24/2014

HYPERHIDROSIS TREATMENTS

Description: This policy addresses treatment of hyperhidrosis, a condition characterized by excessive sweating of the underarms (axillae), palms of the hand (palmar), feet (plantar), face and/or scalp (craniofacial).

Definitions: **Aluminum chloride 20% topical solution:** The aluminum chloride product Drysol™ is FDA approved to be used as an aid in management of hyperhidrosis. It is available by prescription.

Botulinum toxin: Botulinum toxin is produced by the bacterium *Clostridium botulinum* and includes seven distinct serotypes. The potency units of botulinum toxin products are specific to the preparation and assay method utilized. They are not interchangeable and, therefore, units of biological activity of one botulinum toxin product cannot be compared or converted into units of any other botulinum toxin products. OnabotulinumtoxinA (Botox®) has been FDA-approved for the treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents.

Eczematous dermatitis: Inflammation of the skin causing redness, swelling, and itching.

Hyperhidrosis: excessive sweating beyond a level required to maintain normal body temperature.

- **Primary hyperhidrosis** may be caused by overactivity of the sympathetic nervous chain or overactivity of the sweat glands themselves.
- **Secondary hyperhidrosis** results from underlying causes including response to some drugs (e.g., tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs), or from underlying diseases or conditions such as febrile diseases, diabetes mellitus, or menopause. Treatment of secondary hyperhidrosis focuses on treating the underlying cause, such as discontinuation of certain drugs or hormone therapy.

Maceration: Softening and breakdown of skin or other tissue.

Microwave treatment: is designed to heat tissue at the dermal-hypodermal interface, the location of the sweat glands. Prior to treatment, which is administered in the physician's office, the patient receives local anesthesia. Treatment generally consists of two sessions of approximately one hour in duration. One microwave device, the miraDry®System (Miramar Labs® Sunnyvale, CA) was cleared by the FDA through the 510(k) process as substantially equivalent to predicate devices for treating primary axillary hyperhidrosis.

Transthoracic sympathectomy: A surgical procedure during which segments of the sympathetic nervous system that stimulate sweating are cut. Cutting of the nerves at the thoracic level has been investigated as a treatment for hyperhidrosis that is unresponsive to non-surgical treatment. This is primarily a treatment for combined palmar and axillary hyperhidrosis.

Policy:

I. Treatment for All Types of Hyperhidrosis

In addition to use of a treatment considered medically necessary for a specific focus of hyperhidrosis as described in section II, treatment of primary hyperhidrosis (axillary, palmar, plantar, or craniofacial) may be considered **MEDICALLY NECESSARY** in patients with one or more of the following indications:

A. Medical complications secondary to hyperhidrosis including one or more of the following:
   1. Tingling and discoloration (acrocyanosis) of the hands;
   2. Recurrent skin maceration with bacterial or fungal infections;
   3. Recurrent secondary infections;
   4. Persistent eczematous dermatitis despite medical treatment with topical dermatological or systemic anticholinergic agents;

   OR

B. Significant disruption of professional/personal life or significant functional impairment as a result of hyperhidrosis, as documented in the medical record.

II. Treatments for Specific Foci of Hyperhidrosis

A. Axillary

1. The following treatments may be considered **MEDICALLY NECESSARY:**
   a. Aluminum chloride 20% solution;
   b. Botulinum toxin (intradermal injection) for severe primary axillary hyperhidrosis that is inadequately managed with topical agents in patients 18 years and older;
   c. Endoscopic transthoracic sympathectomy (ETS) or surgical excision of axillary sweat glands when BOTH

of the following have failed:

- Aluminum chloride 20% solution administered for a minimum of one month;
  AND
- Botulinum toxin therapy.

2. The following treatments are considered **INVESTIGATIVE:**
   a. Axillary liposuction
   b. Axillary coagulation of lymph glands
   c. Microwave treatment

B. Palmar

1. The following treatments may be considered **MEDICALLY NECESSARY:**
   a. Aluminum chloride 20% solution;
   b. Botulinumtoxin A (intradermal injection) for severe primary palmar hyperhidrosis that is inadequately managed with topical agents in patients 18 years and older;
   c. Endoscopic transthoracic sympathectomy (ETS) when BOTH of the following have failed:
      - Aluminum chloride 20% solution administered for a minimum of one month;
        AND
      - Botulinum toxin therapy.
2. The following treatments are considered **INVESTIGATIVE:**
   a. RimabotulinumtoxinB;
   b. Microwave treatment.

C. Plantar

1. Aluminum chloride 20% solution may be considered **MEDICALLY NECESSARY**.
2. The following treatments are considered **INVESTIGATIVE:**
   a. Botulinum toxin;
   b. Endoscopic transthoracic sympathectomy;
   c. Microwave treatment.

D. Craniofacial

1. The following treatments may be considered **MEDICALLY NECESSARY:**
   a. Aluminum chloride 20% solution;
   b. Endoscopic transthoracic sympathectomy (ETS) when aluminum chloride 20% solution administered for a minimum of one month has failed.
2. The following treatments are considered **INVESTIGATIVE:**
   a. Botulinum toxin;
   b. Microwave treatment.

Coverage: Blue Cross and Blue Shield of Minnesota medical policies apply generally to all Blue Cross and Blue Plus plans and products. Benefit

plans vary in coverage and some plans may not provide coverage for certain services addressed in the medical policies.

Medicaid products and some self-insured plans may have additional policies and prior authorization requirements. Receipt of benefits is subject to all terms and conditions of the member's summary plan description (SPD). As applicable, review the provisions relating to a specific coverage determination, including exclusions and limitations. Blue Cross reserves the right to revise, update and/or add to its medical policies at any time without notice.

For Medicare NCD and/or Medicare LCD, please consult CMS or National Government Services websites.

Refer to the Pre-Certification/Pre-Authorization section of the Medical Behavioral Health Policy Manual for the full list of services, procedures, prescription drugs, and medical devices that require Pre-certification/Pre-Authorization. Note that services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial of claims may result if criteria are not met.

Coding:

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT:

00622 Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy

15877 Suction assisted lipectomy; trunk

15878 Suction assisted lipectomy; upper extremity

32664 Thoracoscopy, surgical; with thoracic sympathectomy

64650 Chemodenervation of eccrine glands; both axillae

64653 Chemodenervation of eccrine glands; other area(s) (e.g., scalp, face, neck), per day

64804 Sympathectomy, cervicothoracic

64809 Sympathectomy, thoracolumbar

HCPCS:

J0585 Injection, onabotulinumtoxinA, 1 unit

J0586 Injection, abobotulinumtoxinA, 5 units

J0587 Injection, rimabotulinumtoxinB, 100 units

J0588 Injection, incobotulinumtoxinA, 1 unit

Policy History:

Developed April 19, 1995

Most recent history:
Revised September 14, 2011
Revised September 12, 2012
Reviewed September 11, 2013
Reviewed September 10, 2014

Cross Reference:
Botulinum Toxin, II-16
Electrotherapy / Electrotherapeutic Devices, VII-25
Liposuction, IV-82