

**Policy: MP258**

**Section: Medical Benefit Policy**

**Subject: Hyperhidrosis**

### **I. Policy:** Hyperhidrosis

### **II. Purpose/Objective:**

To provide a policy of coverage regarding Hyperhidrosis

### **III. Responsibility:**

- A. Medical Directors
- B. Medical Management

### **IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

### **V. Additional Definitions**

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

### **Medicaid Business Segment**

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**DESCRIPTION:**

Hyperhidrosis is a medical condition in which a person perspires excessively and unpredictably. The condition is classified as primary or secondary, depending on if it is a congenital or acquired. Primary hyperhidrosis, (essential or idiopathic hyperhidrosis), is caused by an overactive sympathetic nervous system which causes the eccrine and apocrine glands to become overreactive, and is typically localized to the palms, soles, armpits and face. Secondary hyperhidrosis is the result of an underlying condition, such as Parkinson's disease, diabetes, thyroid disease, pheochromocytoma pituitary disease, gout, hypoglycemia, or menopause. Secondary hyperhidrosis typically affects the whole body.

**INDICATIONS:**

The following treatments are considered medically necessary when specific criteria are met:

**Botulinum toxin A: Requires Prior Authorization by a Plan Medical Director or Designee**

Botulinum toxin A for the treatment of severe primary axillary, palmer, or pedal hyperhidrosis may be considered medically necessary when the following criteria are met:

Physician provided documentation of failure of a 6-month trial of non-surgical treatments with topical dermatologics (e.g., aluminum chloride, tannic acid, glutaraldehyde, anticholinergics), and one of the following:

- a) There is an underlying chronic medical condition such as dermatitis, fungal condition, skin maceration, or secondary microbial condition as a result of hyperhidrosis; or
- b) Sweating is intolerable and causes functional impairment that interferes with member's ability to perform age-appropriate professional or social normal daily activities

Requests for the use of botulinum toxin to treat secondary hyperhidrosis including Frey's syndrome will be evaluated on a per-case basis.

**(See MBP11.0)**

**NOTE: FOR MEDICAID BUSINESS SEGMENT:**

Effective 1/1/20, botulinum toxin is included in the DHS Preferred Drug List. Guidelines for determination of medical necessity can be found in policy **2016.0P Botulinum Toxins**

**Endoscopic transthoracic sympathectomy and/or Surgical excision of axillary sweat glands:**

Endoscopic transthoracic sympathectomy and/or surgical excision of axillary sweat glands: for the treatment of severe primary hyperhidrosis may be considered medically necessary when:

1. Physician provided documentation of failure, contraindication or intolerance of a 6-month trial of non-surgical treatments with topical dermatologics (e.g., aluminum chloride, tannic acid, glutaraldehyde, anticholinergics), systemic anticholinergics, beta-blockers, anti-inflammatory drugs; **AND**
2. Physician provided documentation of failure, contraindication or intolerance to treatment with botulinum toxin A (Botox A) **AND one of the following:**
  - a. the member has medical complications secondary to hyperhidrosis such as, dermatitis, fungal condition, skin maceration, or secondary microbial condition; **OR**
  - b. the member is experiencing a significant impact on activities of daily living as a result of hyperhidrosis;

**Iontophoresis**

Iontophoresis for the treatment of primary focal hyperhidrosis may be considered medically necessary when the following criteria are met:

- Physician provided documentation of failure of a 6 month trial of non-surgical treatments with topical dermatologics (e.g., aluminum chloride, tannic acid, glutaraldehyde, anticholinergics), systemic anticholinergics, beta-blockers, anti-inflammatory drugs, and the member is experiencing a significant impact on activities of daily living as a result of hyperhidrosis **(See MP214 Iontophoresis)**

**EXCLUSIONS:**

The Plan does not cover surgical treatment of secondary hyperhidrosis. Appropriate therapy involves treatment of the underlying condition.

The Plan does **NOT** provide coverage for the use of any of the following treatments of hyperhidrosis because they are considered **experimental, investigational or unproven** for that indication:

- alternative therapies, including but not limited to, homeopathy, massage, acupuncture and herbal drugs (**see MP136**)
- axillary liposuction, including ultrasound-assisted lipoplasty, retrodermal curettage and tumescent suction curettage
- acupuncture (**see MP63**)
- biofeedback (**see MP04**)
- hypnosis
- subdermal Nd-YAG laser
- percutaneous thoracic phenol sympathectomy
- psychotherapy
- repeat/reversal of ETS
- sympathectomy for craniofacial hyperhidrosis
- sympathectomy for plantar hyperhidrosis
- microwave therapy
- Pulsed radiofrequency
- Radiofrequency ablation

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in **MP 15 - Experimental Investigational or Unproven Services or Treatment**.

**CODING ASSOCIATED WITH:** Hyperhidrosis

***The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

- 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
- 32664 Thoracoscopy, surgical; with thoracic sympathectomy
- 15877 Suction assisted lipectomy; trunk
- 15878 Suction assisted lipectomy; upper extremity
- 64650 chemodenervation of eccrine glands; both axillae
- 64653 chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day
- 90880 Hypnotherapy
- 90901 Biofeedback training by any modality
- 97033 Application of a modality to one or more areas; iontophoresis, each 15 minutes
- 97124 Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
- 97810 Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
- 97811 Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
- 97813 Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
- 97814 Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
- J0585 injection, onabotulinumtoxin a, 1 unit
- J0586 injection, abobotulinumtoxin a, 5 units
- J0587 injection, rimabotulinumtoxin b, 100 units
- J0588 injection, incobotulinumtoxin a, 1 unit

**LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.**

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This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 9/19/2011

**Revised:** 10/14 (added iontophoresis), 9/17 (added exclusion); 9/21 (add RF exclusions)

**Reviewed:** 9/12, 9/13, 10/15, 12/16, 9/18, 9/19, 9/20, 9/22

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

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