



Medical Policy

Treatment of Hyperhidrosis

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Policy Number: 406

BCBSA Reference Number: 8.01.19
 NCD/LCD: N/A

Related Policies

Botulinum Toxin for the Treatment of Hyperhidrosis, #[405](#)
 Botulinum Toxin Injection for Muscle and Nerve Conditions, #[006](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Treatment of primary focal hyperhidrosis using the following therapies (see Table 1) may be considered **MEDICALLY NECESSARY** with any of the following medical conditions:

- Acrocyanosis of the hands; or
- History of recurrent skin maceration with bacterial or fungal infections; or
- History of recurrent secondary infections; or
- History of persistent eczematous dermatitis in spite of medical treatments with topical dermatologic or systemic anticholinergic agents.

Table 1. Treatments Considered Medically Necessary and Investigational

Focal Regions	Treatments Considered MEDICALLY NECESSARY	Treatments Considered INVESTIGATIONAL
Axillary	<ul style="list-style-type: none"> • Aluminum chloride 20% solution • Botulinum toxin for severe primary axillary hyperhidrosis that is inadequately managed with topical agents, in patients ≥ 18 y; • ETS and surgical excision of axillary sweat glands, if 	<ul style="list-style-type: none"> • Axillary liposuction • Iontophoresis • Microwave treatment

	conservative treatment (ie, aluminum chloride or botulinum toxin, individually and in combination) has failed	
Palmar	<ul style="list-style-type: none"> Aluminum chloride 20% solution; Botulinum toxin A products for severe primary palmar hyperhidrosis that is inadequately managed with topical agents, in patients ≥ 18 y; ETS, if conservative treatment (ie, aluminum chloride or botulinum toxin type A, individually and in combination) has failed 	<ul style="list-style-type: none"> Rimabotulinumtoxinb Iontophoresis Microwave treatment Radiofrequency ablation
Plantar	<ul style="list-style-type: none"> Aluminum chloride 20% solution 	<ul style="list-style-type: none"> Botulinum toxin Iontophoresis Lumbar sympathectomy Microwave treatment
Craniofacial	<ul style="list-style-type: none"> Aluminum chloride 20% solution; ETS, if conservative treatment (ie, aluminum chloride) has failed 	<ul style="list-style-type: none"> Botulinum toxin Iontophoresis Microwave treatment

Aluminum chloride solution is approved by FDA for treatment of primary hyperhidrosis. At least 1 botulinum toxin product is FDA approved for treatment in adults of severe axillary hyperhidrosis that is inadequately managed by topical agents.

ETS: endoscopic transthoracic sympathectomy; FDA: Food and Drug Administration.

The following treatments may be considered **MEDICALLY NECESSARY** for the treatment of severe secondary gustatory hyperhidrosis (see below for list of gustatory hyperhidrosis conditions):

- Aluminum chloride 20% solution
- Surgical options (ie, tympanic neurectomy), if conservative treatment has failed.

Other treatments are considered **INVESTIGATIONAL** as a treatment for severe secondary gustatory hyperhidrosis including, but not limited to:

- Botulinum toxin
- Iontophoresis.

Treatment of hyperhidrosis is considered **NOT MEDICALLY NECESSARY** in the absence of functional impairment or any of the above medical conditions.

A multispecialty working group defines primary focal hyperhidrosis as a condition that is characterized by visible, excessive sweating of at least 6 months in duration without apparent cause and with at least 2 of the following features: bilateral and relatively symmetric sweating, impairment of daily activities, frequency of at least once per week, age at onset younger than 25 years, positive family history, and cessation of focal sweating during sleep.¹

Gustatory hyperhidrosis conditions:

- Frey syndrome
- Encephalitis

- Syringomyelia
- Diabetic neuropathies
- Herpes zoster parotitis
- Parotid abscess.

Prior Authorization Information

Pre-service approval is required for all inpatient services for all products.

See below for situations where prior authorization may be required or may not be required.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

N/A indicates that this service is primarily performed in an inpatient setting.

	Outpatient
Commercial Managed Care (HMO and POS)	No
Commercial PPO and Indemnity	No
Medicare HMO BlueSM	No
Medicare PPO BlueSM	No

CPT Codes / HCPCS Codes / ICD Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

CPT codes:	Code Description
32664	Thoracoscopy, surgical; with thoracic sympathectomy
69676	Tympanic neurectomy

ICD-9 Diagnosis Codes

ICD-9 Diagnosis codes:	Code Description
705.21	Primary focal hyperhidrosis
705.22	Secondary focal hyperhidrosis

ICD-10 Diagnosis Codes

ICD-10 Diagnosis codes:	Code Description
L74510	Primary Focal Hyperhidrosis, Axilla
L74511	Primary Focal Hyperhidrosis, Face
L74512	Primary Focal Hyperhidrosis, Palms
L74513	Primary Focal Hyperhidrosis, Soles
L7452	Secondary Focal Hyperhidrosis

Description

Hyperhidrosis may be defined as excessive sweating, beyond a level required to maintain normal body temperature in response to heat exposure or exercise. It can be classified as either primary or secondary. Primary focal hyperhidrosis is idiopathic in nature, typically involving the hands (palmar), feet (plantar), or axillae (underarms). Secondary hyperhidrosis can result from a variety of drugs, such as tricyclic

antidepressants, selective serotonin reuptake inhibitors, 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 the scalp or face and predominately over the forehead, lips, and nose. Secondary facial gustatory sweating, in contrast, is usually asymmetric 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. Frey syndrome is an uncommon type of secondary gustatory hyperhidrosis that arises from injury to or surgery near the parotid gland resulting in damage to the secretory parasympathetic fibers of the facial nerve. After injury, these fibers regenerate, and miscommunication occurs between them and the severed postganglionic sympathetic fibers that supply the cutaneous sweat glands and blood vessels. The aberrant connection results in gustatory sweating and facial flushing with mastication. Aberrant secondary gustatory sweating follows up to 73% of surgical sympathectomies and is particularly common after bilateral procedures.

The consequences of hyperhidrosis are primarily psychosocial in nature. Symptoms such as fever, night sweats, or weight loss require further investigation to rule out secondary causes. Sweat production can be assessed with the Minor starch iodine test, which is a simple qualitative measure to identify specific sites of involvement.

A variety of therapies have been investigated for primary hyperhidrosis, including topical therapy with aluminum chloride, oral anticholinergic medications, iontophoresis, intradermal injections of botulinum toxin, endoscopic transthoracic sympathectomy, and surgical excision of axillary sweat glands. Treatment of secondary hyperhidrosis focuses on treatment of the underlying cause, such as discontinuing certain drugs or hormone replacement therapy as a treatment of menopausal symptoms.

Botulinum toxin is a potent neurotoxin that blocks cholinergic nerve terminals; symptoms of botulism include cessation of sweating. Therefore, intracutaneous injections have been investigated as a treatment of gustatory hyperhidrosis and focal primary hyperhidrosis, most frequently involving the axillae or palms. The drawback of this approach is the need for repeated injections, which have led some to consider surgical approaches.

Surgical treatment options include removal of the eccrine glands and/or interruption of the sympathetic nerves. Eccrine sweat glands produce an aqueous secretion, the overproduction of which is primarily responsible for hyperhidrosis. These glands are innervated by the sympathetic nervous system. Surgical removal has been performed in patients with severe isolated axillary hyperhidrosis.

Various surgical techniques of sympathectomy may also be tried. The second (T2) and third (T3) thoracic ganglia are responsible for palmar hyperhidrosis, the fourth (T4) thoracic ganglion controls axillary hyperhidrosis, and the first (T1) thoracic ganglion controls facial hyperhidrosis. Thoracic sympathectomy has been investigated as a potentially curative procedure, primarily for combined palmar and axillary hyperhidrosis that is unresponsive to nonsurgical treatments. While accepted as an effective treatment, sympathectomy is not without complications. In addition to the immediate surgical complications of pneumothorax or temporary Horner syndrome, compensatory sweating on the trunk generally occurs in most patients, with different degrees of severity. Medical researchers have investigated whether certain approaches (eg, T3 vs T4 sympathectomy) result in less compensatory sweating, but there remains a lack of consensus about which approach best minimizes the risk of this adverse effect. In addition, with lumbar sympathectomy for plantar hyperhidrosis, there has been concern about the risk of postoperative sexual dysfunction in both men and women.

The outcome of different surgical and medical treatment modalities is best assessed by using a combination of tools. Quantitative tools include gravimetry, evaporimetry, and the Minor starch iodine test. Qualitative assessment tools include general health surveys and hyperhidrosis-specific surveys. Of these, the Hyperhidrosis Disease Severity Scale has been found to have a good correlation to other assessment tools and to be practical in the clinical setting.

Summary

Hyperhidrosis, or excessive sweating, can lead to impairments in psychologic and social functioning. Various treatments for hyperhidrosis are available, such as topical agents, oral medications, botulinum toxin, and surgical procedures.

There is insufficient evidence on the efficacy and safety of iontophoresis or microwave treatment for treating hyperhidrosis, and on radiofrequency ablation for palmar hyperhidrosis. There is evidence from randomized trials that botulinum toxin improves the net health outcome for patients with axillary hyperhidrosis and evidence that botulinum toxin A products improve the net health outcome for palmar hyperhidrosis. Because of the limited number of studies and high rates of adverse effects, there is insufficient evidence that botulinum toxin B improves the net health outcome for patients with primary palmar hyperhidrosis. There is insufficient evidence on the efficacy of any botulinum toxin products for other types of primary hyperhidrosis, including plantar and secondary hyperhidrosis.

Regarding surgical treatments for hyperhidrosis, data from randomized controlled trials and observational studies show high rates of efficacy of endoscopic transthoracic sympathectomy for primary focal hyperhidrosis, with the exception of plantar hyperhidrosis. There are, however, high rates of compensatory hyperhidrosis which must be considered in the treatment decision. There are insufficient data to draw conclusions on the efficacy of endoscopic lumbar sympathectomy in patients with primary plantar hyperhidrosis.

Policy History

Date	Action
7/2016	New references added from BCBSA National medical policy.
8/2014	Clarified coding information.
11/2013	BCBSA National medical policy review. New investigational indications described. Effective 11/1/2013.
10/2012	Updated Treatment of Hyperhidrosis excluding Botulinum Toxin transferred from medical policy 144, Treatment of Hyperhidrosis.
11/2011	Reviewed at MPG – Plastic Surgery and Dermatology, no changes in coverage.
12/2010	Reviewed at MPG-Plastic Surgery and Dermatology, no coverage changes were made.
12/2009	Reviewed at MPG Plastic Surgery and Dermatology, no changes in coverage were made.
12/2009	New medical policy. Effective 12/1/2009.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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