Introduction

Hyperhidrosis is a medical term that means excessive sweating. There are two types of hyperhidrosis: primary (focal) hyperhidrosis and secondary hyperhidrosis. Primary focal hyperhidrosis is sweating that’s not due to another medical condition or is a side effect of medication. This kind of sweating is its own medical condition, and it takes place on specific parts of the body such as the hands, feet, underarms, or head and neck. These specific areas are known as focal areas.

The other type of hyperhidrosis is secondary hyperhidrosis. This is sweating that happens because of another medical reason such as diabetes, menopause, or obesity.

This policy describes when and what types of treatments may be medically necessary for primary focal and secondary hyperhidrosis.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
Policy Coverage Criteria

**Note:** This policy provides medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Unique clinical circumstances may warrant individual consideration, based on a review of applicable medical records.

### Condition | Medical Necessity
--- | ---
Primary focal hyperhidrosis | Treatment of primary (focal) hyperhidrosis using the following therapies (see Table 1) may be considered medically necessary when 1 or more of the following medical conditions are present:
- Acrocyanosis of the hands or
- History of persistent eczematous dermatitis in spite of medical treatments with topical dermatological or systemic anticholinergic agents or
- History of recurrent secondary infections or
- History of recurrent skin maceration with bacterial or fungal infections

Ongoing/repeat treatments may be considered medically necessary to maintain improvements in physical function.

Treatment of primary (focal) hyperhidrosis is considered not medically necessary in the absence of physical functional impairment (see Definition of Terms below) or any of the medical conditions in the list above.

### Table 1. Treatment of Primary Hyperhidrosis Considered Medically Necessary or Investigational

<table>
<thead>
<tr>
<th>Focal regions</th>
<th>Treatments that may be considered medically necessary (if a medical condition from the list above is present)</th>
<th>Treatments considered investigational (but not limited to):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axillary (underarm)</td>
<td>• Aluminum chloride 20% topical solution*&lt;br&gt;• Botulinum toxin (if not adequately managed with topical agents, in patients 18 years old and older)&lt;br&gt;• Endoscopic transthoracic sympathectomy [ETS] if</td>
<td>• Axillary liposuction&lt;br&gt;• Microwave treatment</td>
</tr>
</tbody>
</table>
### Table 1. Treatment of Primary Hyperhidrosis Considered Medically Necessary or Investigational

<table>
<thead>
<tr>
<th>Focal regions</th>
<th>Treatments that may be considered medically necessary (if a medical condition from the list above is present)</th>
<th>Treatments considered investigational (but not limited to):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>conservative treatment has failed (ie, aluminum chloride or botulinum toxin, individually and in combination)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Iontophoresis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Surgical excision of axillary sweat glands, if conservative treatment has failed (ie, aluminum chloride or botulinum toxin, individually and in combination)</td>
<td></td>
</tr>
<tr>
<td>Palmar (palm of hand)</td>
<td>• Aluminum chloride 20% topical solution*</td>
<td>• RimabotulinumtoxinB</td>
</tr>
<tr>
<td></td>
<td>• Botulinum toxin type A products (if not adequately managed with topical agents, in patients 18 years and older)</td>
<td>• Microwave treatment</td>
</tr>
<tr>
<td></td>
<td>• ETS, if conservative treatment has failed (ie, aluminum chloride or botulinum toxin type A, individually and in combination)</td>
<td>• Radiofrequency ablation</td>
</tr>
<tr>
<td></td>
<td>• Iontophoresis</td>
<td></td>
</tr>
<tr>
<td>Plantar (sole of foot)</td>
<td>• Aluminum chloride 20% topical solution*</td>
<td>• Lumbar sympathectomy</td>
</tr>
<tr>
<td></td>
<td>• Botulinum toxin type A (if not adequately managed with topical agents)</td>
<td>• Microwave treatment</td>
</tr>
<tr>
<td></td>
<td>• Iontophoresis</td>
<td></td>
</tr>
<tr>
<td>Craniofacial (head/face)</td>
<td>• Aluminum chloride 20% topical solution*</td>
<td>• Iontophoresis</td>
</tr>
<tr>
<td></td>
<td>• Botulinum toxin type A products (if not adequately managed with topical agents)</td>
<td>• Microwave treatment</td>
</tr>
<tr>
<td></td>
<td>• ETS, if conservative treatment has failed (ie, aluminum chloride)</td>
<td></td>
</tr>
</tbody>
</table>

*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 inadequately managed by topical agents.

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

### Condition | Medical Necessity
---|---
**Secondary hyperhidrosis** | **Treatment of severe secondary hyperhidrosis may be considered medically necessary (see Table 2) when 1 or more of the following medical conditions are present:**
• Diabetic neuropathies
• Encephalitis
• Frey syndrome
### Condition Medical Necessity

- Herpes zoster parotitis
- Parotid abscess
- Syringomyelia

**Treatment of secondary hyperhidrosis is considered not medically necessary in the absence of a physical functional impairment (see Definition of Terms below) or for other medical conditions not listed above.**

### Table 2. Treatment of Secondary Hyperhidrosis Considered Medically Necessary or Investigational

| Treatments that may be considered medically necessary if a medical condition from the list above is present | Treatments considered investigational (but not limited to): |
| --- |
| • Aluminum chloride 20% topical solution*  
• Botulinum toxin type A  
• Surgical options, (ie tympanic neurectomy), if conservative treatment has failed | • Iontophoresis |

*FDA approved indication.

### Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT 32664</td>
<td>Thoracoscopy, surgical; with thoracic sympathectomy</td>
</tr>
</tbody>
</table>

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).
Definition of Terms

- **Cosmetic:** In this policy, cosmetic services are those which are primarily intended to preserve or improve appearance. Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient’s appearance or self-esteem.

- **Physical functional impairment:** In this policy, physical functional impairment means a limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairments or potential impairments.

- **Reconstructive surgery:** In this policy, reconstructive surgery refers to surgeries performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function.

A multispecialty working group defines primary focal hyperhidrosis as a condition characterized by visible, excessive sweating of at least 6 months’ duration without apparent cause and with 2 or more of the following features:

- Age at onset younger than 25 years old
- Bilateral and relatively symmetric sweating
- Family history of focal hyperhidrosis
- Focal sweating stops during sleep
- Frequency of focal hyperhidrosis is at least once per week
- Impairment of daily activities

**Benefit Application**

Nonsurgical agents may be covered under a pharmacy benefit.
Description

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

Background

Hyperhidrosis has been 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 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 (eg, tricyclic antidepressants, selective serotonin reuptake inhibitors) or underlying diseases/conditions (eg, febrile diseases, diabetes mellitus, menopause). Secondary hyperhidrosis is usually generalized or craniofacial sweating.

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.

Therapeutic Options

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**

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 some cases of secondary hyperhidrosis and primary focal 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 Intervention**

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 have been tested. 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 craniofacial hyperhidrosis. Thoracic sympathectomy has been investigated as a potentially curative procedure, primarily for combined palmar and axillary hyperhidrosis 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 sympathectomy 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.

**Iontophoresis**

Topical iontophoresis (the use of an electric current to introduce various ions through the skin) is a long-standing treatment of palmar or plantar hyperhidrosis and recently adapted for axillary hyperhidrosis. The mechanism of action is not precisely known, but is thought to be related to
plugging of the sweat gland pores. The U.S. Food and Drug Administration (FDA) regulates iontophoresis devices via the 510(k) process.

In tap water iontophoresis (TWI) treatment, the patient places his/her hands or feet into a tap water bath that contains two electrodes, or positions an electrode device in the armpit(s). A small electric current passes through the electrodes. Patients are treated for 20-30 minutes, with treatments every 2 to 3 days for 5 to 10 sessions before an effect is observed. After euhidrosis (perspiration cessation) is achieved, maintenance therapy may consist of treatment every 1-4 weeks after the initial therapy. Iontophoresis is primarily used for focal palmo-plantar hyperhidrosis, since the hands and feet are the easiest body parts to submerge in water.

Outcomes from different surgical and medical treatment modalities are best assessed 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.

**Aluminum Chloride Topical Treatment**

Topical products are the first line of therapy in treating primary (focal) hyperhidrosis. Aluminum chloride, like other metallic salts, exerts its anhidrotic effect by obstructing the distal sweat ducts within the acrosyringium by facilitating the formation of a precipitate. Common side effects usually limit the efficacy of the modality to mild cases of hyperhidrosis. For those patients who respond to antiperspirants, long-term use can sometimes result in degeneration of the eccrine unit and resolution of the localized hyperhidrosis. Drysol & Xerac AC are brand names for topical aluminum chloride solution available by prescription. Aluminum chloride is predominantly used to treat axillary hyperhidrosis, however additional indications include use on the hands, feet and scalp.

**Summary of Evidence**

For individuals who have primary focal hyperhidrosis (ie, axillary, palmar, plantar, craniofacial) who receive iontophoresis, the evidence includes 1 randomized controlled trial (RCT) and case series. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. The RCT found that iontophoresis was less effective than botulinum toxin in the short-term treatment of palmar hyperhidrosis. Additional RCTs are needed comparing iontophoresis to sham or active treatment in patients with various types of primary focal hyperhidrosis. The evidence is insufficient to determine the effects of the technology on health outcomes.
For individuals who have primary axillary hyperhidrosis who receive botulinum toxin type A or B, the evidence includes RCTs. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. Placebo-controlled RCTs have generally found better outcomes in the botulinum toxin groups. Several RCTs have compared botulinum toxin type A formulations in patients with primary axillary hyperhidrosis and have compared botulinum toxin type A and B formulations in patients with axillary hyperhidrosis. Although these studies had small sample sizes, their findings suggest that, with appropriate dosage adjustments, there are similar levels of efficacy and adverse events. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

For individuals who have primary palmar hyperhidrosis who receive botulinum toxin type A, the evidence includes RCTs. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. Placebo-controlled RCTs have generally found better outcomes in the botulinum toxin groups. RCTs comparing botulinum toxin type A formulations in patients with primary palmar hyperhidrosis have generally found no significant difference in outcomes. Although these studies had small sample sizes, their findings suggest that, with appropriate dosage adjustments, there are similar levels of efficacy and adverse events. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

For individuals who have primary palmar hyperhidrosis who receive botulinum toxin type B, the evidence includes 1 RCT. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. One small placebo-controlled RCT did not clearly demonstrate the efficacy of botulinum toxin type B in patients with palmar hyperhidrosis. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have primary plantar hyperhidrosis who receive botulinum toxin type A or B, the evidence includes no RCTs. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. RCTs are needed comparing botulinum toxin to placebo or active treatment in patients with primary plantar hyperhidrosis. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have primary focal hyperhidrosis (ie, axillary, palmar, plantar, craniofacial) who receive microwave treatment, the evidence includes 1 RCT and case series. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. The RCT, conducted in patients with primary axillary hyperhidrosis, found short-term benefit of microwave treatment versus sham therapy, but there was a high rate of skin-related adverse effects. Additional RCTs are needed comparing radiofrequency ablation to sham or active treatment in patients with various types of primary focal hyperhidrosis. The evidence is insufficient to determine the effects of the technology on health outcomes.
For individuals who have primary focal hyperhidrosis (ie, axillary, palmar, plantar, craniofacial) who receive radiofrequency ablation, the evidence includes a nonrandomized cohort study. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. The cohort study, conducted in patients with palmar hyperhidrosis, found a higher cure rate in the surgery group than in the radiofrequency ablation group, and found a similar rate of compensatory sweating in both groups. RCTs are needed comparing radiofrequency ablation to sham or active treatment in patients with various types of primary focal hyperhidrosis. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have primary axillary hyperhidrosis who receive surgical excision of axillary sweat glands, the evidence includes review articles. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. This treatment is considered standard of care for this indication. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

For individuals who have primary axillary and palmar hyperhidrosis who receive endoscopic transthoracic sympathectomy, the evidence includes several RCTs, a meta-analysis, and case series. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. The meta-analysis found a high rate of clinical efficacy after endoscopic transthoracic sympathectomy, although the rate of postoperative compensatory sweating was substantial; other studies had similar findings. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

For individuals who have primary plantar hyperhidrosis who receive lumbar sympathectomy, the evidence includes case series. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. Case series have reported high rates of clinical efficacy, but findings are inconclusive due to lack of control groups. Moreover, there have been substantial rates of compensatory sweating and concerns about adverse effects on sexual functioning. The evidence is insufficient to determine the effects of the technology on health outcomes.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 3.
Table 3. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td><strong>Botulinum Toxin Treatment in Craniofacial, Inguinal, Palmar, Plantar and Truncal Hyperhidrosis</strong></td>
<td>588</td>
<td>Oct 2017</td>
</tr>
</tbody>
</table>

NCT: national clinical trial

Practice Guidelines and Position Statements

**Society of Thoracic Surgeons**

In 2011, an expert consensus statement on the surgical treatment of hyperhidrosis was published by a task force of the Society of Thoracic Surgeons. The document states that endoscopic thoracic sympathectomy is the treatment of choice for patients with primary hyperhidrosis. They further recommend the following treatment strategies (with R referring to “rib” and the number specifies which rib):

- R3 interruption for palmar hyperhidrosis; an R4 interruption is also reasonable. The authors note a slightly higher rate of compensatory sweating with an R3 but R3 is also more effective at treating hyperhidrosis.
- R4 or R5 interruption for palmar-axillary, palmar-axillary-plantar or axillary hyperhidrosis alone; R5 interruption is also an option for axillary hyperhidrosis alone.
- R3 interruption for craniofacial hyperhidrosis without blushing; an R2 and R3 procedure is an option but may lead to a higher rate of compensatory sweating, and also increases the risk of Horner’s syndrome.

**American Academy of Neurology (AAN)**

In 2008, the AAN created guidelines for the use of botulinum neurotoxin for the treatment of autonomic disorders and pain. These guidelines include the following recommendations for botulinum toxin injection as a treatment of hyperhidrosis:

- Should be offered as a treatment option to patients with axillary hyperhidrosis (Level A)
• Should be considered as a treatment option for palmar hyperhidrosis and drooling (Level B)
• May be considered for gustatory sweating (Level C)

**National Institute for Health and Care Excellence (NICE)**

The U.K.’s National Institute for Health and Care Excellence issued guidance in 2014 stating that there is sufficient evidence for the efficacy and safety of endoscopic thoracic sympathectomy for primary facial blushing to support the use of the procedure.36

**Medicare National Coverage**

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

**Regulatory Status**

Drysol™ (aluminum chloride [hexahydrate] 20% topical solution, Person and Covey, Inc.) is approved by the U.S. Food and Drug Administration (FDA) to be used as an aid in the management of hyperhidrosis in the axillae (underarms), palmar (palms of hands), plantar (bottom of feet), and craniofacial (head and face) areas; it is available by prescription.

In 2004 the FDA approved botulinum toxin type A (Botox®) to treat primary axillary hyperhidrosis (severe underarm sweating) that cannot be managed by topical agents. In 2009, this product was renamed to OnabotulinumtoxinA. FDA-approved botulinum toxin* products include:

- 2000: RimabotulinumtoxinB, marketed as Myobloc® (Solstice Neurosciences)
- 2004/2009: OnabotulinumtoxinA, marketed as Botox® (Allergan, Inc.)
- 2009: AbobotulinumtoxinA, marketed as Dysport® (Medicis Pharmaceutical Corporation, Scottsdale, AZ)
- 2010: IncobotulinumtoxinA, marketed as Xeomin® (Merz Pharmaceuticals)

**Note:** Not all of these botulinum toxin products are indicated for treatment of hyperhidrosis.
On July 31, 2009, the FDA approved the following revisions to the prescribing information of botulinum toxin products:

- A Boxed Warning highlighting the possibility of experiencing potentially life-threatening distant spread of toxin effect from injection site after local injection.

- A Risk Evaluation and Mitigation Strategy (REMS) that includes a Medication Guide to help patients understand the risk and benefits of botulinum toxin products.

- Changes to the established drug names to reinforce individual potencies and prevent medication errors. The potency units are specific to each botulinum toxin product, and the doses or units of biological activity cannot be compared or converted from one product to any other botulinum toxin product. The new established names reinforce these differences and the lack of interchangeability among products.

In January 2011, the miraDry® System (Miramar Labs, Inc.; Sunnydale, CA) was cleared by the FDA through the 510(k) process for treating primary axillary hyperhidrosis. This is a microwave device designed to heat tissue at the dermal-hypodermal interface, the location of the sweat glands. Treatment consists of two sessions of approximately one hour in duration. Sessions occur in a physician’s office and local anesthetic is used. FDA Product Codes: NEY, OUB, MWY.

The U.S. Food and Drug Administration (FDA) regulates iontophoresis devices via the 510(k) process. Some machines are only for use by professionals in the office setting. Two devices, commercially available by prescription for home use, are the Drionic® device (General Medical Co., Los Angeles, CA) and the Fisher™ MD-1a Galvanic Unit (R.A. Fischer Co., Northridge, CA). FDA Product Code: EGJ

References

1. Blue Cross and Blue Shield Association Technology Evaluation Center (TEC). Iontophoresis for Medical Indications. TEC Assessments 2003;Volume 18, Tab 3.


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/07/99</td>
<td>Add to Therapy Section - New Policy</td>
</tr>
<tr>
<td>11/12/02</td>
<td>Replace Policy - Policy reviewed without literature review; new review date only.</td>
</tr>
<tr>
<td>09/12/03</td>
<td>Replace Policy - Policy updated regarding iontophoresis as a treatment for hyperhidrosis based on 2003 TEC Assessment; policy statement revised to indicate that this is considered investigational (previously considered medically necessary). Policy changed from “AR” to “BC.”</td>
</tr>
<tr>
<td>03/09/04</td>
<td>Replace Policy - Policy revised regarding surgical treatments of axillary hyperhidrosis; surgical excision considered medically necessary, axillary liposuction considered</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>06/08/04</td>
<td>Replace Policy - Correction to policy statement to remove surgical excision of axillary sweat glands from investigative statement in Policy Section.</td>
</tr>
<tr>
<td>03/08/05</td>
<td>Replace Policy - Policy updated with literature search; policy statement unchanged.</td>
</tr>
<tr>
<td>02/06/06</td>
<td>Codes updated - No other changes.</td>
</tr>
<tr>
<td>06/02/06</td>
<td>Disclaimer and Scope updates - No other changes.</td>
</tr>
<tr>
<td>06/12/07</td>
<td>New PR Policy - Policy replaces BC.8.01.19. In the treatment of primary hyperhidrosis, treatment is considered medically necessary when physical functional impairment exists; and cosmetic when no physical functional impairment is present; axillary liposuction is considered investigational. Botox is indicated as medically necessary treatment for secondary gustatory hyperhidrosis. Definitions of physical functional impairment, cosmetic and reconstructive surgery added to Benefit Application section.</td>
</tr>
<tr>
<td>11/12/07</td>
<td>Code updated - CPT code 89230 removed as directed by RPIW 11/8/07.</td>
</tr>
<tr>
<td>04/08/08</td>
<td>Replace Policy - Policy statement regarding aluminum chloride, iontophoresis, botulinum toxin, endoscopic transthoracic sympathectomy and surgical excision of axillary sweat glands changed from “cosmetic” to “not medically necessary” when there is no physical functional impairment. Description, Rationale and Reference sections updated.</td>
</tr>
<tr>
<td>05/12/09</td>
<td>Replace Policy - Policy updated with literature search; no change to policy statement. References added.</td>
</tr>
<tr>
<td>08/11/09</td>
<td>Code update - 68409 &amp; 64818 added, no other changes.</td>
</tr>
<tr>
<td>12/08/09</td>
<td>Code Update - 89230 added back to policy.</td>
</tr>
<tr>
<td>02/09/10</td>
<td>Code Update - New 2010 code added.</td>
</tr>
<tr>
<td>04/13/10</td>
<td>Replace Policy - Policy updated with literature search; no change to policy statement.</td>
</tr>
<tr>
<td>11/15/10</td>
<td>Codes Updated - Additional J Codes added.</td>
</tr>
<tr>
<td>05/10/11</td>
<td>Replace Policy - Policy updated with literature search; no change to policy statement. Reference added.</td>
</tr>
<tr>
<td>07/10/12</td>
<td>Replace policy. An extensive reformatting of policy statement was done to mirror the layout of Blue Cross Policy 8.01.19 Treatment of Hyperhidrosis. Added Microwave treatment as investigational for primary focal hyperhidrosis. The Description and Rationale sections have been updated. Reference 2 replaced. Added CPT 69676 tympanic neurectomy and 97033 application of modality iontophoresis. Added ICD-9 procedure 99.27 Iontophoresis, added J3490 unclassified drugs, J0588 Injection, incobotulinumtoxinA, 1 unit.</td>
</tr>
<tr>
<td>10/09/12</td>
<td>Update Coding Section – ICD-10 codes are now effective 10/01/2014.</td>
</tr>
<tr>
<td>07/08/13</td>
<td>Replace policy. Policy statement has addition of radiofrequency ablation as investigational for treatment of palmer hyperhidrosis. Rationale updated based on a</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>literature review through May 2013. References 4, 19, 20 and 32 added; other references renumbered or removed. Some policy sections reformatted for readability. Policy statement changed as noted.</td>
</tr>
<tr>
<td>07/14/15</td>
<td>Annual Review. Policy updated with literature search through April, 2015. Policy statements reformatted and edited for clarity. The word “complications” changed to “conditions” in the policy statements. References 5, 33 added, reference 30 removed; others renumbered. Policy statements clarified, intent is unchanged. Coding update: CPT codes 64650, 64653, 64809, 64818, 95923, 97033, and HCPCS codes J0585, J0586, J0587, J0588 &amp; J3490 removed. Retained only CPT code 32664 that specifically relates to this policy. ICD-9 and ICD-10 procedure codes removed; they were listed for informational purposes only. Policy 5.01.512 removed from Related Policies section.</td>
</tr>
<tr>
<td>08/01/16</td>
<td>Annual Review, approved July 12, 2016. Policy updated with literature review through March 22, 2016; references 14, 30 and 37 added. Policy statements unchanged. Code table revised in the Policy Guidelines section, only CPT 32664 is retained for review purposes.</td>
</tr>
<tr>
<td>12/01/17</td>
<td>Annual Review, approved November 9, 2017. Literature review completed through October 2017. No new references added. Policy statements unchanged.</td>
</tr>
<tr>
<td>07/01/18</td>
<td>Minor update, added note that this policy has been updated and added link to updated policy.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2018 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  • Qualified sign language interpreters
  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  • Qualified interpreters
  • Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

Oromo (Cushite):

Français (French):

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladan. Avi sila a kapab genyen enfòmasyon enpòtan konsànpan aplikasyon w an oswa konèsan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka bente kouvèti asirans sante w la oswa pou yo ka ede w avèk defans yo. Se dwa w pou resewwa enfòmasyon sa a ak asisants nan lang ou pale a, san ou pa gen pou peye pou sa. Rate nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):

Hmoob (Hmong):

Ilokano (Ilocano):
Daytoy a Pakdaak ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaak mabalain nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonyo weno coverage babena iti Premera Blue Cross. Daytoy ket mabalain dagiti importante a pelsa iti daytoy a pakdaak. Mabalain nga adda rumbeng nga aramidenyo nga adda sabbay dagiti partikular a naituding nga adda aldaw tapno mapagtalainedyo ti coverage ti salun-atyo weno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong ti bukodyo a pagasao nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):
Japanese (Japanese):
この通知には重要な情報が含まれています。この通知には、Premera Blue Crossの申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている内容が重要な日付をご確認ください。健康保険や無料サポートを維持するには、特定の期限までに行動を起こす必要があります。この言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

Korean (Korean):
본 통지서에 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 귀하는 귀하의 건강 커버리지 계약을 유지하거나 바꾸려면 임의로 요청할 수 있습니다.
귀하는 이러한 정보로 다른 귀하의 만족 부분이 없을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357)으로 전화하십시오.

Laos (Lao):
ພັກລາວແມ່ນສັກພັກລາວທີ່ຈະມີສັກຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢູ່ຢາຍະ ກັບ Premera Blue Cross. PERSISTENCE Cross. 800-722-1471 (TTY: 800-842-5357)