Treatment of Hyperhidrosis

Policy ID:	HHO-DE-MP-1137
Approved By:	Highmark Health Options – Market Leadership
Provider Notice Date:	12/15/2021; 03/01/2023
Original Effective Date:	01/15/2022; 04/01/2023
Annual Approval Date:	10/27/2021; 10/26/2022
Last Revision Date:	10/27/2021; 10/26/2022
Products:	Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 5

Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Highmark Health Options may provide coverage under medical surgical benefits of the Company's Medicaid products for medically necessary treatment of hyperhidrosis.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children's Program (DHCP) and Diamond State Health Plan Plus LTSS (DSHP Plus LTSS) members.

Hyperhidrosis – An excessive sweating that affects the individual's quality of life, resulting in social and work impairment and emotional distress. Primary hyperhidrosis is bilaterally symmetric, focal, excessive sweating of the axillae, palms, soles, or craniofacial region not caused by other underlying conditions. Secondary hyperhidrosis may be focal or generalized and is caused by an underlying medical condition or medication.

PROCEDURES

A prior authorization is required.

Treatment for primary focal hyperhidrosis may be considered medically necessary when any ONE of the following criteria have been met:

- History of recurrent skin maceration with bacterial or fungal infections, (including but not limited to cutaneous disorders such as dermatophytosis (ringworm), pitted keratolysis, viral warts at the sites of hyperhidrosis); or
- History of atopic dermatitis (atopic eczema) in spite of medical treatments with topical dermatological or systemic anticholinergic agents; and

BOTH of the following criteria must be met:

- Unresponsive to or unable to tolerate pharmacotherapy modalities prescribed for excessive sweating (including but not limited to anti-cholinergics, beta-blockers, or benzodiazepines); and
- Topical 20% aluminum chloride or other extra strength antiperspirants are ineffective or result in a severe rash.

Treatment of Hyperhidrosis not meeting the criterial above will be considered not medically necessary.

Any ONE of the following treatments may be considered medically necessary for the corresponding focal region ONLY when the general criteria outlined above have been met.

AXILLARY REGION

- Botulinum toxin A (OnabotulinumtoxinA) for severe primary axillary hyperhidrosis that is inadequately managed with topical agents, in individuals age 18 and older; or
- Iontophoresis; or
- Endoscopic transthoracic sympathectomy (ETS) and surgical excision of axillary sweat glands, if conservative treatment (i.e., aluminum chloride or botulinum toxin, individually and in combination) has failed.

Initial authorization for botulinum toxin A (OnabotulinumtoxinA~~)~~ for axillary hyperhidrosis will expire in 3 months from the original authorization date for any diagnosis. Additional authorization may be given if documentation of an objective measurable effect is provided indicating clinical improvement of the condition. Absence of clinical improvement of axillary hyperhidrosis will be considered not medically necessary for further injections of botulinum toxin A (OnabotulinumtoxinA).
Treatment of axillary hyperhidrosis not meeting the criteria above will be considered not medically necessary.

Any ONE of the following treatments may be considered medically necessary for the corresponding focal region ONLY when the general criteria outlined above have been met.

PALMAR REGION

- Botulinum toxin A (OnabotulinumtoxinA) for severe primary palmar hyperhidrosis that is inadequately managed with topical agents, in individuals age 18 and older; or
- Iontophoresis; or
- ETS, if conservative treatment (i.e., aluminum chloride or botulinum toxin type A, individually and in combination) has failed.

Treatment of palmar hyperhidrosis not meeting the criterial above will be considered not medically necessary.

Any ONE of the following treatments may be considered medically necessary for the corresponding focal region ONLY when the general criteria outlined above have been met.

PLANTAR REGION

- Botulinum toxin A (OnabotulinumtoxinA) for severe primary plantar hyperhidrosis that is inadequately managed with topical agents, in individuals age 18 and older.

Treatment of plantar hyperhidrosis not meeting the criterial above will be considered not medically necessary.

Any ONE of the following treatments may be considered medically necessary for the corresponding focal region ONLY when the general criteria outlined above have been met.

CRANIOFACIAL REGION

- Botulinum toxin A (OnabotulinumtoxinA) for severe craniofacial hyperhidrosis that is inadequately managed with topical agents, in individuals 18 years and older; **or**
- ETS, if conservative treatment (e.g., aluminum chloride) has failed.

Treatment of craniofacial hyperhidrosis not meeting the criterial above will be considered not medically necessary.

SECONDARY HYPERHIDROSIS: SECONDARY GUSTATORY HYPERHIDROSIS

The following treatment may be considered medically necessary for severe gustatory hyperhidrosis when the above general criteria have been met:

- Surgical options (e.g., tympanic neurectomy, if conservative treatment has failed).

Treatment of secondary hyperhidrosis not meeting the criterial above will be considered not medically necessary.

NOTE: Microwave treatment, lumbar sympathectomy and radiofrequency ablation are considered experimental/investigational and, therefore, non-covered because the safety and/or effectiveness of these services cannot be established by the available published peer-reviewed literature.

POST-PAYMENT AUDIT STATEMENT

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

PLACE OF SERVICE: INPATIENT/OUTPATIENT

Experimental/investigational (E/I) services are not covered regardless of place of service.

Treatment of Hyperhidrosis is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

CODING REQUIREMENTS

CPT codes	Description
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.

69676	Tympanic neurectomy; unilateral.
97033	Application of a modality to one or more areas; Iontophoresis, each 15 minutes.

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES

Codes						
97033	64650	32664	L74.510			

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Codes						
97033	64653	32664	L74.512			

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Codes						
97033	L74.513					

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES

Codes						
32664	L74.511					

COVERED DIAGNOSIS FOR PROCEDURE CODES

Codes						
69676	L74.52					

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES

Codes						
64653	L74.512					

REIMBURSEMENT

Participating facilities will be reimbursed per their Highmark Health Options contract.

Reference

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POLICY UPDATE HISTORY

10/27/2021	Approved in Medical Policy
12/2022	Approved in QI/UM
10/26/2022	Annual review; approved in medical policy committee
11/2022	Approved in QI/UM