

Hyperhidrosis Treatments, Surgical 107

Table of Content

[Description & Definitions](#)
[Criteria](#)
[Document History](#)
[Coding](#)
[Policy Approach and Special Notes](#)
[References](#)
[Keywords](#)

| | |
|----------------------------------|--------------|
| Effective Date | 6/1/2026 |
| Next Review Date | 2/2027 |
| Coverage Policy | Surgical 107 |
| Version | 10 |

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details*.

Description & Definitions:

Hyperhidrosis Treatments are procedures to treat the disorder causing excessive sweating from areas of the body such as the axilla, face, palms, and soles.

Sympathectomy is a minimally invasive surgical procedure to cut or clamp the nerve and at least one sympathetic ganglion is removed to reduce signals.

Other common names: miraDry System, Microwave Therapy, Dermadry, Endoscopic thoracic sympathectomy (ETS), Primary Focal Palmar, Primary Focal Craniofacial and Gustatory Hyperhidrosis (Frey's Syndrome), Primary Focal Plantar, Suction curettage

Criteria:

Hyperhidrosis surgical treatment is considered medically necessary for indications of **ALL** of the following:

- Individual has severe disabling symptoms
- Individuals who have failed to adequately respond to treatment using a nonsurgical management option, are not appropriate (eg, medication, botulinum toxin injection, iontophoresis) or unable to tolerate oral pharmacotherapy prescribed.
- Individual diagnosed with Primary focal hyperhidrosis for **1 or more** of the following:
 - Axillary (axilla) or PAH
 - Craniofacial (face)
 - Palmar (palms)
 - Plantar (soles of feet)
- Surgical treatment of primary hyperhidrosis for **1 or more** of the following:
 - **Primary Focal Axillary Hyperhidrosis (PAH)** for **1 or more** of the following:
 - Chemical thoracic sympathectomy
 - Chemodenervation
 - Endoscopic sympathetic ablation by electrocautery
 - Endoscopic thoracic sympathectomy (ETS)
 - Excision of **axillary** sweat glands (including use of curettage and liposuction)
 - Lumbar sympathectomy
 - Open thoracic sympathectomy
 - Thoracoscopic sympathectomy

- Tumescent or ultrasonic liposuction for axillary hyperhidrosis
- Video-assisted endoscopic thoracic ganglionectomy
- Video-assisted thoracic sympathectomy (VATS)
- **Primary Focal Craniofacial** for **1 or more** of the following:
 - Chemodenervation
 - Endoscopic thoracic sympathectomy (ETS) as last resort
- **Primary Focal Palmar** for **1 or more** of the following:
 - Chemodenervation
 - Endoscopic thoracic sympathectomy (ETS)
- **Primary Focal Plantar** for **1 or more** of the following:
 - Chemodenervation

Hyperhidrosis surgical treatment is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- ETS for plantar hyperhidrosis
- Laser treatment
- Microwave therapy
- MiraDry thermal energy procedure
- Oxybutynin gel
- Repeat/reversal of ETS
- Surgical treatment of secondary hyperhidrosis due to the underlying condition (e.g., hyperthyroidism, diabetes mellitus or hyperpituitarism).
- Ultrasound

Document History:

Revised Dates:

- 2026: February – Implementation date of June 1, 2026. Removed microwave thermal energy from criteria. Updated exceptions.
- 2025: February
- 2024: February
- 2019: November
- 2015: April

Reviewed Dates:

- 2023: February
- 2022: February
- 2021: February
- 2020: February
- 2018: May
- 2017: January

Origination Date: April 2014

Coding:

Medically necessary with criteria:

| Coding | Description |
|--------|---|
| 32664 | Thoracoscopy, surgical; with thoracic sympathectomy |
| 64804 | Sympathectomy, cervicothoracic |
| 64809 | Sympathectomy, thoracolumbar |
| 64818 | Sympathectomy, lumbar |
| 17999 | Unlisted procedure, skin, mucous membrane, and subcutaneous tissue |
| 15877 | Suction assisted lipectomy; trunk |
| 15878 | Suction assisted lipectomy; upper extremity |
| 97024 | Application of a modality to 1 or more areas; diathermy (eg, microwave) |

Considered Not Medically Necessary:

| Coding | Description |
|--------|-------------|
| | None |

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage
 - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products
 - Policy is applicable to Sentara Health Plan Medicare products
 - See MCG for Iontophoresis
- Authorization requirements
 - Pre-certification by the Plan is required.
- Special Notes:
 - This medical policy expresses Sentara Health Plan's determination of medical necessity of services, and they are based upon a review of currently available clinical information. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
 - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

References:

References used include but are not limited to the following: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

Code of Federal Regulations. Title 21 Chapter I Subchapter H Part 890 Subpart F § 890.5525. Iontophoresis device. 2.4.2026. Retrieved 2.9.2026. <https://www.ecfr.gov/current/title-21/section-890.5525>

US Food and Drug Administration. US Food and Drug Administration. Device, iontophoresis. Page last updated 2.9.2026. Retrieved 2.9.2026. <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpdc/classification.cfm?id=EGJ>

Symplr Evidence Analysis. Formally Hayes. Evidence Analysis Research Brief. March 10, 2025. Tap Water Iontophoresis for Treatment of Hyperhidrosis. Retrieved 2.9.2026. <https://evidence.hayesinc.com/report/earb.tapwater4316>

Symplr Evidence Analysis. Formally Hayes. Evolving Evidence Review. Annual Review: Nov 6, 2025. miraDry Microwave Therapy (miraDry Inc.) for Management of Primary Axillary Hyperhidrosis. Retrieved 2.9.2026. <https://evidence.hayesinc.com/report/eer.miradry4054>

Centers for Medicare and Medicaid Services. CMS.gov. Retrieved 2.9.2026. <https://www.cms.gov/search/cms?keys=hyperhidrosis>

Commonwealth of Virginia. Department of Medical Assistance Services. DMAS.gov. Retrieved 2.9.2026. https://vamedicaid.dmas.virginia.gov/pdf_chapter/practitioner#gsc.tab=0&gsc.q=hyperhidrosis&gsc.sort=

National Comprehensive Cancer Network. NCCN.gov. Retrieved 2.9.2026. <https://www.nccn.org/search-result?indexCatalogue=nccn-search-index&searchQuery=hyperhidrosis>

International Hyperhidrosis Society. Endoscopic thoracic sympathectomy (ETS). 2025. Retrieved 2.9.2026. <https://www.sweathelp.org/hyperhidrosis-treatments/ets-surgery.html>

PubMed. National Library of Medicine. Chang, J., Flynn, C., Chan, S., King, J., & Horton, M. (2023). Uniportal thoracoscopic sympathectomy for hyperhidrosis. Multimedia manual of cardiothoracic surgery : MMCTS, 2023, 10.1510/mmcts.2023.053. Retrieved 2.9.2026. <https://doi.org/10.1510/mmcts.2023.053>

MCG Informed Care Strategies. Sympathectomy by Thoracoscopy or Laparoscopy. ORG: S-1072 (ISC). 29th Edition. 2025. Retrieved 2.9.2026. <https://careweb.careguidelines.com/ed29/index.html>

Keywords:

Sympathectomy, hyperhidrosis, SHP Hyperhidrosis Treatment, SHP Surgical 107, Chemical thoracic sympathectomy, Endoscopic sympathetic ablation by electrocautery, Endoscopic thoracic sympathectomy, Excision of axillary sweat glands, Lumbar sympathectomy, Open thoracic sympathectomy, Thoracoscopic sympathectomy, Tumescent or ultrasonic liposuction for axillary hyperhidrosis, Video-assisted endoscopic thoracic ganglionectomy, Video-assisted thoracic sympathectomy, VATS, excessive sweating, surgical hyperhidrosis treatment, Sympathectomy, microwave thermolysis, endoscopic thoracic sympathectomy (ETS), endoscopic lumbar sympathectomy (ELS), minimally invasive subcutaneous curettage, Microwave thermolysis, miraDry