Sentara Health Plans

Medicaid

Hyperhidrosis Treatments, Surgical 107

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Effective Date	4/2014
Next Review Date	2/2026
Coverage Policy	Surgical 107
Version	8

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

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 hyperhydrosis 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
        - Microwave thermolysis (e.g., miraDry microwave therapy)
        - Open thoracic sympathectomy
        - Thoracoscopic sympathectomy
        - Tumenescent 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
- 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:

- 2025: February
- 2024: February
- 2019: November
- 2015: April

Reviewed Dates:

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

U.S. Food and Drug Administration (FDA) - approved only products only.

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.

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 Virginia Medicaid products
  - See MCG for Iontophoresis
- Authorization requirements
  - Pre-certification by the Plan is required.
- Special Notes:
  - Medicaid
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. 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.

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

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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, Tumenescent 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