Sentara Health Plans

Commercial

Hyperhidrosis Treatments

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Effective Date	4/2014
Next Review Date	2/13/2024
Coverage Policy	Surgical 107
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for detail.

Purpose:

This policy addresses Hyperhidrosis Treatments.

Description & Definitions:

Hyperhidrosis Treatments are procedure to treat the disorder causing excessive sweating, beyond what the body requires to maintain thermal control includes from (axilla, face, palms, and soles).

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

Criteria:

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

- Individual has severe disabling symptoms
- individuals who have failed to adequately respond to treatment using a Nonsurgical management option or are not appropriate (eg, medication, botulinum toxin injection, iontophoresis)
- The surgical treatment of **primary axillary hyperhidrosis (PAH)** for **1 or more** of the following:
    - Chemical thoracic sympathectomy
    - 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 etc.) for severe primary palmar hyperhidrosis only
    - Open thoracic sympathectomy
    - Thoracoscopic sympathectomy
    - Tumenescent or ultrasonic liposuction for axillary hyperhidrosis
    - Video-assisted endoscopic thoracic ganglionectomy
    - Video-assisted thoracic sympathectomy (VATS)

Hyperhidrosis treatments is considered **Not Medically Necessary** for ANY indications, to include but not limited to:

- repeat/reversal of ETS
- sympathectomy for craniofacial hyperhidrosis

sympathectomy for plantar hyperhidrosis

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.

Document History:

Revised Dates:

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

Reviewed Dates:

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

Effective Date:

- April 2014

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

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.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

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