Sentara® Health Plans

Commercial

Hyperhidrosis Treatments, Surgical 107

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Effective Date	6/1/2026
Next Review Date	2/2027
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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 *.

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

        - 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
- 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. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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 Commercial products
  - See MCG for Iontophoresis
- Authorization requirements
  - Pre-certification by the Plan is required.
- 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.

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).

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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