Treatment of primary focal hyperhidrosis using the outlined therapies may be considered medically necessary with any of the following medical conditions:

- Acrocyanosis of the hands
- History of recurrent skin maceration with bacterial or fungal infections
- History of recurrent secondary infections
- History of persistent eczematous dermatitis despite medical treatments with topical dermatologic or systemic anticholinergic agents

Treatment of hyperhidrosis is considered not medically necessary in either of the following:

- In the absence of functional impairment
- In the absence of any of the above medical conditions

Treatment of severe secondary gustatory hyperhidrosis may be considered medically necessary for the treatment of severe secondary gustatory hyperhidrosis (see Policy Guidelines section for list of gustatory hyperhidrosis conditions):

- Aluminum chloride 20% solution
- Surgical options (i.e., tympanic neurectomy) when conservative treatment (i.e., aluminum chloride) has failed

The following treatment is considered investigational as a treatment for severe secondary gustatory hyperhidrosis including, but not limited to:

- Iontophoresis

**NOTE:** Refer to Appendix A to see the policy statement changes (if any) from the previous version.

**Policy Guidelines**

**Note:** This policy does not address pharmacy treatment of hyperhidrosis including Botulinum toxin. For pharmacy treatment see Blue Shield of California Medication Policy: Botulinum Toxin.

Table PG1 summarizes the treatments that may be considered medically necessary by focal region.

### Table PG1. Treatments for Hyperhidrosis Considered Medically Necessary

<table>
<thead>
<tr>
<th>Focal Regions</th>
<th>Treatments Considered Medically Necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axillary</td>
<td>• Aluminum chloride 20% solution</td>
</tr>
<tr>
<td></td>
<td>• Endoscopic transthoracic sympathectomy (ETS) and surgical excision of axillary sweat glands, if conservative treatment (i.e., aluminum chloride, individually and in combination) has failed</td>
</tr>
<tr>
<td>Palmar</td>
<td>• Aluminum chloride 20% solution</td>
</tr>
<tr>
<td></td>
<td>• ETS, if conservative treatment (i.e., aluminum chloride, individually and in combination) has failed</td>
</tr>
<tr>
<td>Plantar</td>
<td>• Aluminum chloride 20% solution</td>
</tr>
<tr>
<td>Craniofacial</td>
<td>• Aluminum chloride 20% solution</td>
</tr>
<tr>
<td></td>
<td>• ETS, if conservative treatment (i.e., aluminum chloride) has failed</td>
</tr>
</tbody>
</table>

**Note:** Aluminum chloride solution is approved by the FDA for treatment of primary hyperhidrosis, but is excluded from coverage according to Blue Shield Evidence of Coverage (EOC) General Exclusions and Limitations because it is available over the counter without a prescription. ETS: endoscopic transthoracic sympathectomy; FDA: Food and Drug Administration.
Table PG2 summarizes the treatments that are considered investigational by focal region.

Table PG2. Treatments for Hyperhidrosis Considered Investigational

<table>
<thead>
<tr>
<th>Focal Regions</th>
<th>Treatments Considered Investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axillary</td>
<td>• Axillary liposuction</td>
</tr>
<tr>
<td></td>
<td>• Iontophoresis</td>
</tr>
<tr>
<td></td>
<td>• Microwave treatment</td>
</tr>
<tr>
<td></td>
<td>• Radiofrequency ablation</td>
</tr>
<tr>
<td>Palmar</td>
<td>• Iontophoresis</td>
</tr>
<tr>
<td></td>
<td>• Microwave treatment</td>
</tr>
<tr>
<td></td>
<td>• Radiofrequency ablation</td>
</tr>
<tr>
<td>Plantar</td>
<td>• Iontophoresis</td>
</tr>
<tr>
<td></td>
<td>• Lumbar sympathectomy</td>
</tr>
<tr>
<td></td>
<td>• Microwave treatment</td>
</tr>
<tr>
<td></td>
<td>• Radiofrequency ablation</td>
</tr>
<tr>
<td>Craniofacial</td>
<td>• Iontophoresis</td>
</tr>
<tr>
<td></td>
<td>• Microwave treatment</td>
</tr>
<tr>
<td></td>
<td>• Radiofrequency ablation</td>
</tr>
</tbody>
</table>

A multispecialty working group have defined primary focal hyperhidrosis as a condition characterized by visible, excessive sweating of at least 6 months in duration without apparent cause and with at least 2 of the following features:

- Bilateral and relatively symmetric sweating
- Impairment of daily activities
- Frequency of at least once per week
- Age at onset younger than 25 years
- Positive family history
- Cessation of focal sweating during sleep

The Hyperhidrosis Disease Severity Scale (HDSS) is used by patients to rate the severity of their symptoms on a scale of 1 to 4 (see Table PG3).

Table PG3. The Hyperhidrosis Disease Severity Scale

<table>
<thead>
<tr>
<th>Score</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>My underarm sweating is never noticeable and never interferes with my daily activities</td>
</tr>
<tr>
<td>2</td>
<td>My underarm sweating is tolerable but sometimes interferes with my daily activities</td>
</tr>
<tr>
<td>3</td>
<td>My underarm sweating is barely tolerable and frequently interferes with my daily activities</td>
</tr>
<tr>
<td>4</td>
<td>My underarm sweating is intolerable and always interferes with my daily activities</td>
</tr>
</tbody>
</table>

Gustatory Hyperhidrosis Conditions

- Frey syndrome
- Encephalitis
- Syringomyelia
- Diabetic neuropathies
- Herpes zoster parotitis
- Parotid abscess

Coding

A variety of iontophoretic devices can be purchased for home use. There are no specific HCPCS codes for these pieces of durable medical equipment. Tap water iontophoresis devices (usually requested using the miscellaneous Durable medical equipment (DME) code E1399) are sometimes used as a treatment for some types of hyperhidrosis (particularly plantar or palmar). Many of these devices are available over the counter without prescription and are relatively inexpensive. Therefore, please refer to the Benefits section of the member’s evidence of coverage (EOC) for a coverage determination.
Although usually self-performed in the home setting, if this service was provided in an office setting, CPT code 97033 (Application of a modality to 1 or more areas; iontophoresis, each 15 minutes) is a physical therapy code that describes this service. Note this treatment is considered investigational for hyperhidrosis per this policy.

CPT code 97024 is defined as Application of a modality to 1 or more areas; diathermy (e.g., microwave). Note this treatment is considered investigational for Hyperhidrosis per this policy.

The following CPT codes may include related surgical procedures:

- **11450**: Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair*
- **11451**: Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair*
  *Note: Although the above descriptors indicate these excision codes are for hidradenitis, several coding sites indicate that providers might use these codes for axillary gland removal for hyperhidrosis as well.
- **32664**: Thoracoscopy, surgical; with thoracic sympathectomy
- **64818**: Sympathectomy, lumbar**
  **Note: This surgery is considered investigational for plantar hyperhidrosis per this policy.
- **69676**: Tympanic neurectomy

**Description**

Hyperhidrosis, or excessive sweating, can lead to impairments in psychologic and social functioning. Various treatments for hyperhidrosis are available, such as topical antiperspirant agents (e.g., aluminum chloride 20% solution), oral medications, and surgical procedures.

**Related Policies**

- N/A

**Benefit Application**

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. 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.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

**Regulatory Status**

Drysol™ (Person and Covey), an aluminum chloride (hexahydrate) 20% topical solution, was approved by the U.S. Food and Drug Administration (FDA) as an aid in the management of hyperhidrosis (axillae, palmar, plantar, craniofacial); it is available by prescription. Additional topical medicines approved by the FDA include Hypercare Topical and Xerac AC. Qbrexa™ (glycopyrronium) 2.4% topical cloth was FDA-approved for use in the treatment of primary axillary hyperhidrosis in 2018.
In 2011, the miraDry® System (Miramar Labs) was cleared for marketing by the FDA through the 510(k) process for treating primary axillary hyperhidrosis. This microwave device is designed to heat tissue at the dermal-hypodermal interface, the location of the sweat glands. Treatment consists of two sessions for a total duration of approximately one hour. Sessions occur in a physician’s office, and a local anesthetic is used. The device is currently not approved for the treatment of palmar or plantar hyperhidrosis.

**Rationale**

**Background Hyperhidrosis**

Hyperhidrosis has been defined as excessive sweating, beyond a level required to maintain normal body temperature, in response to heat exposure or exercise. It can be classified as primary or secondary. Primary focal hyperhidrosis is idiopathic, typically involving the hands (palmar), feet (plantar), or axillae (underarms). Secondary hyperhidrosis can result from a variety of drugs (e.g., tricyclic antidepressants, selective serotonin reuptake inhibitors) or underlying diseases/conditions (e.g., febrile diseases, diabetes, menopause). Secondary hyperhidrosis is usually generalized or craniofacial sweating.

Secondary gustatory hyperhidrosis is excessive sweating on ingesting highly spiced foods. This trigeminovascular reflex typically occurs symmetrically on the scalp or face and predominately over the forehead, lips, and nose. Secondary facial gustatory occurs independently of the nature of the ingested food. This phenomenon frequently occurs after injury or surgery in the region of the parotid gland. Frey syndrome is an uncommon type of secondary gustatory hyperhidrosis that arises from injury to or surgery near the parotid gland resulting in damage to the secretory parasympathetic fibers of the facial nerve. After the injury, these fibers regenerate, and miscommunication occurs between them and the severed postganglionic sympathetic fibers that supply the cutaneous sweat glands and blood vessels. The aberrant connection results in gustatory sweating and facial flushing with mastication. Aberrant secondary gustatory sweating follows up to 73% of surgical sympathectomies and is particularly common after bilateral procedures.

The consequences of hyperhidrosis are primarily psychosocial. Symptoms such as fever, night sweats, or weight loss require further investigation to rule out secondary causes. Sweat production can be assessed with the Minor starch-iodine test, which is a simple qualitative measure to identify specific sites of involvement.

**Treatment**

A variety of therapies have been investigated for primary hyperhidrosis, including topical therapy with aluminum chloride, oral anticholinergic medications, iontophoresis, endoscopic transthoracic sympathectomy, and surgical excision of axillary sweat glands. Treatment of secondary hyperhidrosis focuses on the treatment of the underlying cause, such as discontinuing certain drugs or hormone replacement therapy as a treatment for menopausal symptoms.

Iontophoresis uses an electrical current to deliver medication transdermally. A charged ionic drug is placed on the skin with an electrode of the same charge, which drives the drug into the skin, with the purpose of achieving better penetration of the drug into the underlying tissue. The benefits of this method would be an enhancement of treatment effects and a reduction in adverse events associated with systemic administration of the drug.

Surgical treatment options include removal of the eccrine glands and/or interruption of the sympathetic nerves. Eccrine sweat glands produce an aqueous secretion, the overproduction of which is primarily responsible for hyperhidrosis. These glands are innervated by the sympathetic nervous system. Surgical removal has been performed in patients with severe isolated axillary hyperhidrosis.
Various surgical techniques of sympathectomy have been tested. The second (T2) and third (T3) thoracic ganglia are responsible for palmar hyperhidrosis, the fourth (T4) thoracic ganglion controls axillary hyperhidrosis, and the first (T1) thoracic ganglion controls craniofacial hyperhidrosis. Thoracic sympathectomy has been investigated as a potentially curative procedure, primarily for combined palmar and axillary hyperhidrosis unresponsive to nonsurgical treatments. While accepted as an effective treatment, sympathectomy is not without complications. In addition to the immediate surgical complications of pneumothorax or temporary Horner syndrome, compensatory sweating on the trunk generally occurs in most patients, with different degrees of severity. Medical researchers have investigated whether certain approaches (e.g., T3 sympathectomy vs T4 sympathectomy) result in less compensatory sweating, but there remains a lack of consensus about which approach best minimizes the risk of this adverse event. Also, with lumbar sympathectomy for plantar hyperhidrosis, there has been concern about the risk of postoperative sexual dysfunction in both men and women.

**Outcome Measures**

Outcomes from different surgical and medical treatment modalities are best assessed using a combination of tools. Quantitative tools include gravimetry, evaporimetry, and the Minor starch-iodine test. Qualitative assessment tools include general health surveys and hyperhidrosis-specific surveys. Of these, the Hyperhidrosis Disease Severity Scale (see Appendix Table 1) has had a good correlation to other assessment tools and is practical in the clinical setting.

**Literature Review**

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. Randomized controlled trials are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

**Treatment for Primary Focal Hyperhidrosis (i.e., Axillary, Palmar, Plantar, Craniofacial)**

**Clinical Context and Therapy Purpose**

The purpose of iontophoresis, endoscopic transthoracic sympathectomy, lumbar sympathectomy, and surgical excision of axillary sweat glands in patients who have primary focal hyperhidrosis is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

**Patients**

The relevant population of interest is individuals with primary focal hyperhidrosis. Hyperhidrosis is defined as excessive sweating, beyond a level required to maintain normal body temperature, in response to heat exposure or exercise. It can be classified as primary or
Secondary. Primary focal hyperhidrosis is idiopathic, typically involving the hands (palmar), feet (plantar), or axillae (underarms).

**Interventions**
The therapies being considered are iontophoresis, endoscopic transthoracic sympathectomy, lumbar sympathectomy, and surgical excision of axillary sweat glands.

**Comparators**
A variety of therapies have been investigated for primary hyperhidrosis, including topical therapy with aluminum chloride and oral anticholinergic medications.

**Outcomes**
The general outcomes of interest are symptoms, quality of life, and treatment-related morbidity. Outcomes from different surgical and medical treatment modalities are best assessed using a combination of tools. Quantitative tools include gravimetry, evaporimetry, and the Minor starch-iodine test. Qualitative assessment tools include general health surveys and hyperhidrosis-specific surveys. Of these, the Hyperhidrosis Disease Severity Scale (see Appendix Table 1) has had a good correlation to other assessment tools and is practical in the clinical setting.

**Review of Evidence**

**Systematic Review**
Wade et al (2017) published a comprehensive systematic review and meta-analysis, sponsored by the National Institute for Health Research, evaluating the following therapies for hyperhidrosis: iontophoresis, anticholinergic medications, curettage, and energy-based technologies that damage sweat glands (laser, microwave). Because endoscopic thoracic sympathectomy is accepted as a last-line treatment, it was not evaluated. The literature search, conducted through July 2016, identified 50 studies for inclusion: 32 RCTs, 17 nonrandomized comparative studies, and a large prospective case series. Study quality was assessed using the Cochrane risk of bias tool.

Reviewers concluded that the evidence for the clinical effectiveness and safety of second-line treatment for primary hyperhidrosis was limited due to a large number of studies with a high risk of bias, mostly due to poorly reported methods. Assessments from this review for iontophoresis and microwave appear in the respective sections below.

**Iontophoresis**
The Wade et al (2017) systematic review identified 10 studies using iontophoresis: 4 RCTs, 5 nonrandomized comparative studies, and a case series. All studies were rated as having a high or unclear risk of bias. Comparators differed across studies: placebo (3 studies), botulinum (2 studies), no treatment (2 studies), and iontophoresis plus anticholinergic (2 studies). Sample sizes ranged from 10 to 112, with the case series having the sample size of 112. Most studies treated hands, with some studies treating hands and feet. A meta-analysis could not be conducted due to the heterogeneity across studies. Reviewers concluded that the evidence was low quality but consistent, showing a potential benefit of iontophoresis compared with no treatment or placebo; however, when compared with botulinum injections, iontophoresis appeared less effective and had a short duration of effect.

A 2003 Blue Cross Blue Shield Association Technology Evaluation Center (TEC) Assessment on iontophoresis for a variety of medical conditions concluded that the evidence was insufficient to determine whether its impact on the treatment of any hyperhidrosis exceed those of placebo or an alternative treatment. TEC Assessment investigators identified only 3 small studies (range, 10-60 patients), all of which were conducted in patients with palmar hyperhidrosis.

Several case series and an RCT have been identified since 2003. The RCT by Rajagopal et al (2014) compared iontophoresis plus topical aluminum chloride hexahydrate with botulinum toxin injection but did not provide data on the efficacy of this therapy compared with placebo. The
trial included 60 patients with a baseline Hyperhidrosis Disease Severity Scale (HDSS) score of 3 or 4 (see Appendix Table 1 for scoring). Patients were randomized to treatment with iontophoresis 3 times weekly or to 1 botulinum toxin injection in each hand, with 2 weeks between treatments. HDSS scores were recorded at 4 weeks; nonresponders were permitted to crossover to the other treatment arm. At the end of the initial 4 weeks, improvement (defined as a decrease of at least 1 point in HDSS score) was identified in 24 (80%) of 30 patients in the botulinum toxin group and 14 (47%) of 30 patients in the iontophoresis group ($p=0.007$). Sixteen patients in the iontophoresis arm crossed over to the botulinum toxin arm, with 12 showing excellent improvement after an additional 4 weeks. In contrast, only 1 of the 6 patients who crossed over to the iontophoresis arm showed improvement after a second 4-week treatment period. In this relatively small sample with a relatively short intervention period, iontophoresis was less effective than botulinum toxin.

Among the case series is a retrospective study Dogruk Kacar et al (2014) from Turkey, which included 21 pediatric patients under age 18. Most patients (n=16) had palmoplantar hyperhidrosis. Nineteen patients completed the course of 21 tap water iontophoresis sessions. Among study completers, mean self-report treatment effectiveness score, rated on a 0-to-10 visual analog scale, was 6.36 at the end of treatment. Seventeen (89.5%) of 19 patients reported a 50% or more decrease in sweating at the end of treatment. Another representative series is the McAleer and Collins (2014) study from Ireland, which included 28 patients. Patients received a minimum of 9 treatments over 21 days in a clinical setting. Twenty (80%) of the 25 patients for whom data were available after hospital administration of tap water iontophoresis reported a moderate or great amount of improvement in symptoms and a moderate or great improvement in quality of life.

**Section Summary: Iontophoresis**

There is insufficient evidence that iontophoresis is an effective treatment of primary focal hyperhidrosis. A systematic review of 10 studies suggested a potential benefit of iontophoresis; however, the studies had either low or unclear risk of bias. The single RCT among the 10 studies found iontophoresis less effective than botulinum toxin in the short-term treatment of palmar hyperhidrosis. RCTs are needed to show that iontophoresis is more effective than placebo treatment or at least as effective as alternative therapies.

**Microwave Treatment**

**Systematic Reviews**

Hsu et al (2017) conducted a systematic review of studies investigating the use of microwave-based therapies for the treatment of axillary hyperhidrosis. The literature search, conducted through June 2016, identified an RCT (described below) and 4 single-arm observational studies (one of which is described below). Studies were published between 2012 and 2016. The total number of patients in the 5 studies was 189 (range, 7-120). Administration of a microwave therapy differed by frequency (1 to 3 times) and length of treatment intervals (2 weeks to 3 months) among the studies. Follow-up extended to 1 year in 4 of the studies. All studies reported HDSS scores. Additional outcomes included osmidrosis evaluation (3 studies), gravimetric assessments (2 studies), and Dermatologic Life Quality Index (1 study). All studies reported that microwave therapy was effective in reducing sweating in patients with axillary hyperhidrosis, with HDSS scores decreasing by at least 1 point throughout follow-up. The most common adverse events reported were swelling, pain, edema, hair loss, altered sensation, and palpable bumps. Reviewers concluded that while efficacy was indicated and side effects were mild, additional RCTs with larger sample sizes and longer follow-up would be needed.

The Wade (2017) systematic review included only a single RCT in its evaluation (the same RCT included in the Hsu systematic review described above) and detailed below in the RCT section. While the RCT results suggested a benefit of microwave compared with placebo, the evidence was of low quality. Also, evidence of safety was insufficient.
**Randomized Controlled Trials**

An RCT by Glaser et al (2012) evaluated a microwave device for treating primary focal hyperhidrosis. This device applied microwave energy to superficial skin structures with the intent of inducing thermolysis of the eccrine and apocrine sweat glands. This industry-sponsored, double-blind trial randomized 120 adults with primary axillary hyperhidrosis 2:1 to active (n=61) or sham (n=39) treatment. Treatment consisted of 2 sessions, separated by approximately 2 weeks.

Patients who responded adequately after 1 session or declined further treatment did not undergo the second session; a third procedure was allowed within 30 days for patients who still had a high level of sweating after 2 sessions. All patients in the sham group had 2 sessions. In the active treatment group, 11 (9%) patients had 1 session, 60 (74%) had 2 sessions, and 10 (8%) patients had 3 sessions. The primary efficacy end point was an HDSS score of 1 or 2 (see Appendix Table 1) at the 30-day follow-up; HDSS score at 6 months was a secondary outcome.

A total of 101 (84%) of 120 patients completed the study. At 30 days, 89% of the active treatment group and 54% of the sham group had an HDSS score of 1 or 2 (p<0.001). At 6 months, 67% of the active treatment group vs 44% of the sham group had an HDSS score of 1 or 2 (p=0.02).

Unblinding occurred at 6 months. Twelve-month data were available for the active treatment group only; 69% reported an HDSS score of 1 or 2. There were 45 procedure-related adverse events in 23 (28%) of the active treatment group vs 5 (13%) of the sham group. The most frequently reported adverse event was altered sensation; no serious adverse events were reported. Compensatory sweating was reported by 2 patients in each group (mean duration, 52 days). The authors noted that study data provided an opportunity to identify areas for improvement in the treatment protocol including waiting longer between treatments and using a higher dose of energy at the second session.

**Observational Studies**

Hong et al (2012) conducted an industry-sponsored case series of 31 patients with primary axillary hyperhidrosis treated with microwave therapy using the miraDry system. All patients had an HDSS score of 3 or 4 at baseline. The primary efficacy outcome (the proportion of patients whose HDSS score decreased to 1 or 2) was 28 (90%) at 6 and 12 months posttreatment. Longer term skin-related adverse events (that all resolved over time) were altered sensation in the skin of the axillae (65% of patients; median duration, 37 days) and palpable bumps under the skin of the axillae (71% of patients; median duration, 41 days).

**Section Summary: Microwave Treatment**

A systematic review identified an RCT and 4 case series evaluating the use of microwave therapy for the treatment of hyperhidrosis. The RCT reported on a short-term benefit of microwave treatment in reducing hyperhidrosis but also reported a high rate of skin-related adverse events (e.g., pain, altered sensation). The case series also reported reductions in sweating, but sample sizes were small. Additional controlled trials with long-term follow-up in the treatment and control groups, a longer period of blinding, and a consistent treatment protocol would be needed to confirm the efficacy of this treatment and better define the risk-benefit ratio.

**Radiofrequency Ablation**

Purtuloglu et al (2013) evaluated radiofrequency ablation (RFA) as a treatment for patients with severe bilateral palmar hyperhidrosis resistant to conservative treatment. The study was conducted in Turkey and retrospectively reviewed outcomes after RFA (n=48) or transthoracic sympathectomy (n=46). Patients were not randomized to treatment group. After a mean follow-up of 15 months, palmar hydrosis was absent in 36 (75%) patients in the RFA group and 44 (96%) patients in the surgery group. The difference in outcomes between groups was statistically significant, favoring the surgical intervention (p<0.01). Six patients in each group reported moderate or severe compensatory sweating (p=0.78).
Mostafa et al (2019) conducted a RCT of radiofrequency ablation compared to botulinum toxin type A in 80 patients with primary palmar hyperhidrosis. Both groups showed improvements from baseline in HDSS scores at 1 week, 1 month, and 2 months after treatment, but scores in the radiofrequency ablation group were significantly lower (indicating more improvement with RFA) than in the botulinum toxin group at 1 week, 1 month, and 2, 6, and 12 months after treatment. Rummaneethorn et al (2019) compared RFA to botulinum toxin A in 20 patients with primary axillary hyperhidrosis. At the endpoint visit (week 12), the botulinum toxin A group had significantly lower reduction of mean HDSS score than the RFA group with 1.60 (0.59) versus 2.05 (0.68), respectively (p = 0.0332).

**Section Summary: Radiofrequency Ablation**

One nonrandomized comparative study found RFA inferior to surgical sympathectomy for patients with severe bilateral palmar hyperhidrosis resistant to conservative treatment. Two small RCTs that compared RFA to botulinum toxin A in patients with palmar or axillary hyperhidrosis had conflicting results. The body of evidence is insufficient to assess the use of RFA as a treatment for hyperhidrosis.

**Surgical Interventions**

**Surgical Excision of Axillary Sweat Glands**

Surgery may involve removal of the subcutaneous axillary sweat glands without removal of any skin, limited excision of skin, and removal of surrounding subcutaneous sweat glands, or a more radical excision of skin and subcutaneous tissue en bloc. Depending on the completeness of surgical excision, treatment is effective in 50% to 95% of patients.

**Section Summary: Surgical Excision of Axillary Sweat Glands**

Sweat gland excision has been found to be effective in 50% to 95% of appropriately selected patients.

**Endoscopic Transthoracic Sympathectomy**

**Systematic Reviews**

Several RCTs and a meta-analysis have compared different surgical approaches; there were no sham-controlled randomized trials. Deng et al (2011) published a meta-analysis of data from RCTs and observational studies published through 2010 that evaluated endoscopic thoracoscopic sympathectomy for patients with palmar hyperhidrosis. Reviewers pooled outcomes data from different approaches to sympathectomy (i.e., single-ganglia blockage [T2, T3, T4], multiganglia blockage [T2-3, T2-4, T3-4]). (Note that T refers to the rib.) Based on these analyses, reviewers concluded that T3 (11 studies) approaches and T3-4 (2 studies) had the "best" clinical efficacy (i.e., postoperative resolution of symptoms). The T3 approach resulted in a 97.9% pooled efficacy rate, and the T3-4 approach resulted in a 100% pooled efficacy rate. In the studies for which data were available, the pooled rate of postoperative compensatory sweating was 40% after T3 surgery. Data on compensatory sweating after T3-4 surgery were available from only 1 study (60 patients); a pooled analysis could not be performed.

**Randomized Controlled Trials**

Subsequent RCTs have compared levels (rib location) of sympathectomy. These trials tended to have relatively small sample sizes (i.e., <100 patients). For example, Baumgartner et al (2011) in the United States studied 121 patients with disabling palmar hyperhidrosis. Patients were randomized to bilateral sympathectomy over T2 (n=61 patients) or T3 (n=60 patients). Six (5%) of 121 patients (3 in each group) were considered treatment failures (i.e., had recurrent palmar sweating to a bothersome level). There were no significant differences between groups in the reported subjective change in plantar or axillary sweating after surgery. At 6 months, the mean level of compensatory sweating (0-10 severity scale) was 4.7 for the T2 group and 3.8 for the T3 group (p = 0.04). Similarly, at 1 year, the mean severity rating of compensatory sweating was 4.7 in the T2 group and 3.7 in the T3 group (p = 0.09). Yuncu et al (2013) in Turkey randomized 60 patients with axillary hyperhidrosis to T3-4 surgery (n=17) or T3 surgery (n=43). There were no significant differences between groups in postoperative satisfaction. At 1-year follow-up, the
incidence of compensatory sweating was lower in the T3 group (79%) than in the T3-4 group (100%).

**Case Series**
There also are case series on transthoracic sympathectomy for treating primary focal hyperhidrosis.30,31,32,33 Case series have generally reported high success rates for palmar and axillary hyperhidrosis, although there are potential adverse events, most commonly compensatory sweating. For example, Karamustafoglu et al (2014) in Turkey reported on 80 patients with primary hyperhidrosis (axillary and/or palmar).32 All 80 patients responded to a questionnaire a mean of 35 months after surgery. Seventy-one (89%) of the 80 patients were very satisfied with the surgical outcome, and the other 11% were dissatisfied. Compensatory sweating was reported by 62 (78%) patients. Moreover, a series by de Andrade Filho et al (2013) reported on complications after thoracic sympathectomy in 1731 patients with palmar, axillary, or craniofacial hyperhidrosis.30 Thirty days after surgery, 1531 (88%) of patients reported compensatory sweating. Among the 1531 patients, compensatory sweating was mild in 473 (31%), moderate in 642 (42%), and severe in 416 (27%). Gustatory sweating was reported by 334 (19%) of the 1731 patients.

Several retrospective chart reviews evaluated the effects of the procedure on subgroups of patients with hyperhidrosis. Lembranca et al (2017) reviewed the charts of patients with palmar or axillary hyperhidrosis who did not respond to oxybutynin chloride treatment who then underwent thoracic sympathectomy (n=167) and patients who were referred directly to surgical treatment (n=570).34 Both groups showed improvements in hyperhidrosis and quality of life (>90%). De Campos et al (2017) assessed the quality of life among 15 patients with palmar hyperhidrosis who were unresponsive following a thoracic sympathectomy and underwent a re-sympathectomy.35 Quality of life scores improved from “poor” or “very poor” to “excellent” or “very good” in 14 of the 15 patients. Fukuda et al (2018) reviewed charts of patients with craniofacial hyperhidrosis as a primary complaint (n=40) and patients with craniofacial hyperhidrosis as a secondary complaint (n=136).36 Over 90% of patients in both groups reported a moderate or great reduction in hyperhidrosis following the procedure. Greater improvements in quality of life were reported among the patients with craniofacial hyperhidrosis that was a secondary complaint, though both groups had improved quality of life. A large proportion of patients (92%) reported compensatory hyperhidrosis. Vasconcelos-Castro et al (2019) reported a case series of 23 pediatric patients (ages 11-19 years) with primary palmar hyperhidrosis who underwent bilateral thoracoscopic sympathectomy. Sweating severity improved in all patients, with a mean decrease from baseline of 1.95 on the HDSS (P < 0.05 compared to baseline). Compensatory sweating occurred in 47.8% of patients.37

**Section Summary: Endoscopic Transthoracic Sympathectomy**
RCTs and a meta-analysis of RCTs have supported the efficacy of endoscopic transthoracic sympathectomy at various levels for palmar, axillary, and craniofacial hyperhidrosis. These data are complemented by case series, which have found high efficacy rates, but also high rates of compensatory sweating for these conditions.

**Lumbar Sympathectomy**
Lima 2020 (2020) conducted a systematic review and meta-analysis of lumbar sympathectomy for plantar hyperhidrosis.38 Eight studies were identified, including a total of 517 patients. One RCT met inclusion criteria; the other studies were case series. In all of the studies, lumbar sympathectomy was conducted following transthoracic sympathectomy. Resolution of symptoms occurred in 92% of patients when mechanical sympathectomy was used with clipping or resection of the lymph nodes between L2 and L5, with similar results regardless of resection level. Overall, 44% of patients had mild to severe compensatory sweating after a mean 6 months of follow-up. The RCT was conducted in 30 women at a single hospital in Brazil.38 The primary outcome measure was a quality of life questionnaire that was developed for use in patients undergoing thoracic sympathectomy. After 6 months, patients in the intervention group had a greater improvement in quality of life relative to the control group patients; 53%
reported worsening compensatory sweating. This study was limited by its small sample size, use of an unvalidated outcome measure, and lack of blinded outcome assessment.

A 2004 review from a multispecialty working group on hyperhidrosis stated that lumbar sympathectomy is not recommended for plantar hyperhidrosis because of associated sexual dysfunction; this article did not cite any data documenting sexual dysfunction. To date, there are very few studies on endoscopic lumbar sympathectomy for focal plantar hyperhidrosis and only 1 small comparative study with methodological limitations.

Section Summary: Lumbar Sympathectomy
There is insufficient evidence in support of lumbar sympathectomy for treating plantar hyperhidrosis; case series have found lower rates of efficacy for plantar compared with axillary or palmar hyperhidrosis, and there are concerns for adverse events in sexual functioning. One RCT conducted among 30 women at a single center in Brazil was limited by its small sample size and lack of blinded outcome assessment. There are insufficient data to conclude that any particular approach to surgery results in lower rates of compensatory sweating.

Treatment for Severe Secondary Gustatory Hyperhidrosis

Clinical Context and Therapy Purpose
The purpose of iontophoresis, endoscopic transthoracic sympathectomy, lumbar sympathectomy, and surgical excision of axillary sweat glands in patients who have severe secondary gustatory hyperhidrosis is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Patients
The relevant population(s) of interest is individuals with severe secondary gustatory hyperhidrosis. Secondary gustatory hyperhidrosis is excessive sweating on ingesting highly spiced foods. This trigeminovascular reflex typically occurs symmetrically on the scalp or face and predominately over the forehead, lips, and nose. Secondary facial gustatory occurs independently of the nature of the ingested food. This phenomenon frequently occurs after injury or surgery in the region of the parotid gland. Frey syndrome is an uncommon type of secondary gustatory hyperhidrosis that arises from injury to or surgery near the parotid gland resulting in damage to the secretory parasympathetic fibers of the facial nerve.

Interventions
The therapies being considered are iontophoresis, and tympanic neurectomy.

Treatment of secondary hyperhidrosis focuses on treatment of the underlying cause, such as discontinuing certain drugs or hormone replacement therapy as a treatment for menopausal symptoms.

Comparators
Alternatives for treatment of secondary gustatory hyperhidrosis include topical therapy (e.g., aluminum chloride) and treatment of the underlying cause (e.g., dietary changes).

Outcomes
The general outcomes of interest are symptoms, quality of life, and treatment-related morbidity. Outcomes from different surgical and medical treatment modalities are best assessed using a combination of tools. Quantitative tools include gravimetry, evaporimetry, and the Minor starch-iodine test. Qualitative assessment tools include general health surveys and hyperhidrosis-specific surveys. Of these, the Hyperhidrosis Disease Severity Scale (see Appendix Table 1) has had a good correlation to other assessment tools and is practical in the clinical setting.
Review of Evidence

Iontophoresis
As noted in the section on primary focal hyperhidrosis, a TEC Assessment (2003) assessing iontophoresis for a variety of medical conditions concluded that the evidence was insufficient to determine whether iontophoresis for the treatment of any hyperhidrosis improves outcomes. Neither the TEC Assessment nor subsequent literature searches have identified any RCTs evaluating iontophoresis for gustatory hyperhidrosis.

Tympanic Neurectomy
Review articles by Clayman et al (2006) and de Bree et al (2007), have described various medical and surgical treatments for Frey syndrome. Tympanic neurectomy has been described as a treatment, with satisfactory control reported in 82% of patients. Also, this surgical treatment is generally definitive without a need for repeated interventions.

Section Summary: Tympanic Neurectomy for Secondary Gustatory Hyperhidrosis
Review articles have supported the use of tympanic neurectomy for patients with severe gustatory sweating.

Summary of Evidence

Primary Focal Hyperhidrosis

Iontophoresis
For individuals who have primary focal hyperhidrosis (i.e., axillary, palmar, plantar, craniofacial) who receive iontophoresis, the evidence includes a systematic review, a randomized controlled trial (RCT), and case series. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. The RCT found that iontophoresis was less effective than botulinum toxin in the short-term treatment of palmar hyperhidrosis. Additional RCTs are needed comparing iontophoresis with sham or active treatment in patients with various types of primary focal hyperhidrosis. The evidence is insufficient to determine the effects of the technology on health outcomes.

Microwave
For individuals who have primary focal hyperhidrosis (i.e., axillary, palmar, plantar, craniofacial) who receive microwave treatment, the evidence includes a systematic review, an RCT, and case series. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. The RCT, conducted in patients with primary axillary hyperhidrosis, found a short-term benefit of microwave treatment vs sham therapy, but there was a high rate of skin-related adverse events. Additional RCTs are needed comparing microwave treatment with sham or active treatment in patients with various types of primary focal hyperhidrosis. The evidence is insufficient to determine the effects of the technology on health outcomes.

Radiofrequency Ablation
For individuals who have primary focal hyperhidrosis (i.e., axillary, palmar, plantar, craniofacial) who receive radiofrequency ablation, the evidence includes 2 small RCTs and a nonrandomized cohort study. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. One nonrandomized comparative study found RFA inferior to surgical sympathectomy for patients with severe bilateral palmar hyperhidrosis resistant to conservative treatment. Two small RCTs that compared RFA to botulinum toxin A in patients with palmar or axillary hyperhidrosis had conflicting results. The evidence is insufficient to determine the effects of the technology on health outcomes.

Surgery
For individuals who have primary axillary hyperhidrosis who receive surgical excision of axillary sweat glands, the evidence includes review articles. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. The evidence has shown that excision is highly effective,
and this treatment is considered standard of care for this indication. The evidence is sufficient to
determine that the technology results in a meaningful improvement in the net health outcome. For
dividuals who have primary axillary and palmar hyperhidrosis who receive endoscopic
transthoracic sympathectomy, the evidence includes several RCTs, a meta-analysis, and case
series. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. The
meta-analysis found a high rate of clinical efficacy after endoscopic transthoracic
sympathectomy, although the rate of postoperative compensatory sweating was substantial.
Subsequent studies have supported these findings. The evidence is sufficient to determine that
the technology results in a meaningful improvement in the net health outcome.

For individuals who have primary plantar hyperhidrosis who receive lumbar sympathectomy, the
evidence includes one RCT conducted at a single center in Brazil, case series, and a systematic
review. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. Case
series have reported high rates of clinical efficacy, but findings are inconclusive due to lack of
control groups. The RCT was limited by its small sample size and lack of blinded outcome
assessment. Moreover, there have been substantial rates of compensatory sweating and
concerns about adverse events on sexual functioning. The evidence is insufficient to determine
the effects of the technology on health outcomes.

Secondary Gustatory Hyperhidrosis
For individuals who have severe secondary gustatory hyperhidrosis who receive iontophoresis
the evidence includes uncontrolled studies and systematic reviews. Relevant outcomes are
symptoms, quality of life, and treatment-related morbidity. The systematic reviews did not
identify any relevant RCTs. RCTs are needed to evaluate the safety and efficacy of these
treatments for severe secondary gustatory hyperhidrosis. The evidence is insufficient to
determine the effects of the technology on health outcomes.

For individuals who have severe secondary gustatory hyperhidrosis who receive tympanic
neurectomy, the evidence includes uncontrolled studies and systematic reviews. Relevant
outcomes are symptoms, quality of life, and treatment-related morbidity. This treatment has high
success rates, without the need for repeated interventions, and is considered standard of care
for this indication. The evidence is sufficient to determine that the technology results in a
meaningful improvement in the net health outcome.

Supplemental Information
Practice Guidelines and Position Statements

Society of Thoracic Surgeons
In 2011, the Society of Thoracic Surgeons published an expert consensus statement on the
surgical treatment of hyperhidrosis.44 The document stated that endoscopic thoracic
sympathectomy is the treatment of choice for patients with primary hyperhidrosis. It further
recommended the following treatment strategies (with R referring to rib and the number to
which rib):

- R3 interruption for palmar hyperhidrosis; an R4 interruption is also reasonable. The authors
  note a slightly higher rate of compensatory sweating with R3, but R3 is also more
  effective at treating hyperhidrosis.
- R4 or R5 interruption for palmar-axillary, palmar-axillary-plantar, or axillary hyperhidrosis
  alone; R5 interruption is also an option for axillary hyperhidrosis alone.
- R3 interruption for craniofacial hyperhidrosis without blushing; an R2 and R3 procedure is
  an option but may lead to a higher rate of compensatory sweating, and also increases
  the risk of Horner syndrome.

According to the statement, endoscopic thoracic sympathectomy has been recommended for
patients with severe symptoms that cannot be managed with other therapies who meet the
following criteria:

- Onset of hyperhidrosis at an early age (before 16 years)
• <25 years of age at time of surgery
• Body mass index <28 kg/m²
• No sweating during sleep
• No significant comorbidities
• Resting heart rate <55 beats per minute

National Institute for Health and Care Excellence
In 2014, the National Institute for Health and Care Excellence issued guidance stating that there was sufficient evidence for the efficacy and safety of endoscopic thoracic sympathectomy for primary facial blushing to support the use of the procedure.\cite{47}

The Institute also issued guidance in 2014 on endoscopic thoracic sympathectomy for primary hyperhidrosis of the upper limb.\cite{48}

The guidance stated that “current evidence on the efficacy and safety of endoscopic thoracic sympathectomy for primary hyperhidrosis of the upper limb is adequate to support the use of this procedure.” Also: “Due to the risk of side effects, this procedure should only be considered in patients suffering from severe and debilitating primary hyperhidrosis that has been refractory to other treatments.”

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 2.

Table 2. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>Unpublished</td>
<td>Management of Palmar Hyperhidrosis with Hydrogel-based Iontophoresis</td>
<td>13</td>
<td>Aug 2018</td>
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<td>Ongoing</td>
<td>MiraDry Treatment for Focal Axillary Hyperhidrosis (MiraDry Tx)</td>
<td>24</td>
<td>Jul 2020</td>
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<tr>
<td></td>
<td>Hyperhidrosis of the Residual Limb in Patients With Amputations: Developing a Treatment Approach</td>
<td>25</td>
<td>Dec 2023</td>
</tr>
<tr>
<td></td>
<td>Prospective Multicentric Open Randomised Controlled Trial Comparing Topical Aluminium Chloride to OnabotulinumtoxinA Intradermal Injections in Residual Limb Hyperhidrosis (Lower Limbs)</td>
<td>54</td>
<td>Sep 2020</td>
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<tr>
<td></td>
<td>Evaluation of Compensatory Sweating After Unilateral Videothoracoscopic Sympathectomy of the Dominant Side or Sequential Bilateral Videothoracoscopic Sympathectomy: a Multicentric Randomized Trial</td>
<td>200</td>
<td>Dec 2020</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

References

2. Blue Cross Blue Shield Association Technology Evaluation Center (TEC). Iontophoresis for Medical Indications. TEC Assessments 2003; Volume 18, Tab 3.


**Documentation for Clinical Review**

Please provide the following documentation:
- History and physical and/or consultation notes including:
  - Type of diagnosed hyperhidrosis
  - Pertinent comorbidities
  - Previous treatment plan(s) and response(s)

Post Service (in addition to the above, please include the following):
- Procedure report(s)

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>11450</td>
<td>Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair</td>
</tr>
<tr>
<td></td>
<td>11451</td>
<td>Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair</td>
</tr>
<tr>
<td></td>
<td>15877</td>
<td>Suction assisted lipectomy; trunk</td>
</tr>
<tr>
<td></td>
<td>15878</td>
<td>Suction assisted lipectomy; upper extremity</td>
</tr>
<tr>
<td></td>
<td>32664</td>
<td>Thoracoscopy, surgical; with thoracic sympathectomy</td>
</tr>
<tr>
<td></td>
<td>64650</td>
<td>Chemodenervation of eccrine glands; both axillae</td>
</tr>
<tr>
<td></td>
<td>64653</td>
<td>Chemodenervation of eccrine glands; other area(s) (e.g., scalp, face, neck), per day</td>
</tr>
<tr>
<td></td>
<td>69676</td>
<td>Tympanic neurectomy</td>
</tr>
<tr>
<td></td>
<td>64802</td>
<td>Sympathectomy, cervical</td>
</tr>
<tr>
<td></td>
<td>64804</td>
<td>Sympathectomy, cervicothoracic</td>
</tr>
<tr>
<td></td>
<td>64809</td>
<td>Sympathectomy, thoracolumbar</td>
</tr>
<tr>
<td></td>
<td>64818</td>
<td>Sympathectomy, lumbar</td>
</tr>
</tbody>
</table>
### Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member’s illness, injury, or disease.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.
Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.
## Appendix A

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment of Hyperhidrosis 8.01.19</strong></td>
<td><strong>Treatment of Hyperhidrosis 8.01.19</strong></td>
</tr>
<tr>
<td><strong>Policy Statement:</strong></td>
<td><strong>Policy Statement:</strong></td>
</tr>
<tr>
<td>Treatment of primary focal hyperhidrosis using the following therapies (see Table P1) may be considered <em>medically necessary</em> with any of the following medical conditions:</td>
<td>Treatment of primary focal hyperhidrosis using the outlined therapies may be considered <em>medically necessary</em> with any of the following medical conditions:</td>
</tr>
<tr>
<td>- Acrocyanosis of the hands</td>
<td>I. Acrocyanosis of the hands</td>
</tr>
<tr>
<td>- History of recurrent skin maceration with bacterial or fungal infections</td>
<td>II. History of recurrent skin maceration with bacterial or fungal infections</td>
</tr>
<tr>
<td>- History of recurrent secondary infections</td>
<td>III. History of recurrent secondary infections</td>
</tr>
<tr>
<td>- History of persistent eczematous dermatitis despite medical treatments with topical dermatologic or systemic anticholinergic agents</td>
<td>IV. History of persistent eczematous dermatitis despite medical treatments with topical dermatologic or systemic anticholinergic agents</td>
</tr>
<tr>
<td>Treatment of hyperhidrosis is considered <em>not medically necessary</em> in either of the following:</td>
<td>Treatment of hyperhidrosis is considered <em>not medically necessary</em> in either of the following:</td>
</tr>
<tr>
<td>- In the absence of functional impairment</td>
<td>I. In the absence of functional impairment</td>
</tr>
<tr>
<td>- In the absence of any of the above medical conditions</td>
<td>II. In the absence of any of the above medical conditions</td>
</tr>
<tr>
<td>Either of the following treatments may be considered <em>medically necessary</em> for the treatment of severe secondary gustatory hyperhidrosis (see Policy Guidelines section for list of gustatory hyperhidrosis conditions):</td>
<td>Treatment of severe secondary gustatory hyperhidrosis may be considered <em>medically necessary</em> when either of the following criteria is met:</td>
</tr>
<tr>
<td>- Aluminum chloride 20% solution</td>
<td>I. Aluminum chloride 20% solution is used</td>
</tr>
<tr>
<td>- Surgical options (i.e., tympanic neurectomy) if conservative treatment (i.e., aluminum chloride) has failed</td>
<td>II. Utilized surgical options (i.e., tympanic neurectomy) when conservative treatment (i.e., aluminum chloride) has failed</td>
</tr>
<tr>
<td>Other treatments are considered investigational as a treatment for severe secondary gustatory hyperhidrosis including, but not limited to:</td>
<td>The following treatment is considered <em>investigational</em> as a treatment for severe secondary gustatory hyperhidrosis including, but not limited to:</td>
</tr>
<tr>
<td>- Botulinum toxin</td>
<td>I. Iontophoresis</td>
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