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Treatment of Hyperhidrosis

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Related Policies (if applicable)
None

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

Primary Focal Hyperhidrosis
Treatment of primary focal hyperhidrosis using the following therapies **may be considered medically necessary** for individuals with any of the following medical conditions, as outlined in Table 1 below:

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

Table 1: Treatments Considered Medically Necessary and Experimental, Investigational and/or Unproven.

Focal Regions	Treatments Considered Medically Necessary	Treatments Considered Experimental, Investigational and/or Unproven
Axillary	• OnabotulinumtoxinA (see **NOTE 1**) for severe primary axillary hyperhidrosis inadequately managed with topical agents, in patients 18 years and older; • ETS and surgical excision of axillary sweat glands, if conservative treatment has failed. • Subdermal laser treatment.	• Axillary liposuction; • Iontophoresis; • Microwave treatment; • Radiofrequency ablation;
Palmar	• ETS if conservative treatment has failed.	• RimabotulinumtoxinB; • Iontophoresis; • Microwave treatment; • Radiofrequency ablation; • Subdermal laser treatment.
Plantar	N/A	• OnabotulinumtoxinA; • AbobotulinumtoxinA; • IncobotulinumtoxinA; • RimabotulinumtoxinB; • Iontophoresis; • Lumbar sympathectomy; • Microwave treatment; • Radiofrequency ablation; • Subdermal laser treatment.
Craniofacial	ETS, if conservative treatment has failed.	• OnabotulinumtoxinA; • AbobotulinumtoxinA; • IncobotulinumtoxinA; • RimabotulinumtoxinB; • Iontophoresis; • Microwave treatment; • Radiofrequency ablation; • Subdermal laser treatment.

ETS: endoscopic transthoracic sympathectomy. N/A: non-applicable.

NOTE 1: OnabotulinumtoxinA is the only botulinum toxin product that is U.S. Food and Drug Administration approved for treatment of adults with severe axillary hyperhidrosis inadequately managed by topical agents.

Secondary Hyperhidrosis

The following treatment **may be considered medically necessary** for the treatment of severe secondary gustatory hyperhidrosis (see Description section for list of gustatory hyperhidrosis conditions):

- Surgical options (i.e., tympanic neurectomy) if conservative treatment has failed.

Other treatments **are considered experimental, investigational, and/or unproven** as a treatment for severe secondary gustatory hyperhidrosis including, but not limited to:

- Botulinum toxin;
- Iontophoresis;
- Subdermal laser treatment.

Other

Treatment of hyperhidrosis **is considered not medically necessary** in the absence of functional impairment or any medical condition not included above.

Policy Guidelines

A variety of iontophoretic devices can be purchased for home use. There are no specific HCPCS codes for these pieces of DME (durable medical equipment). Code E1399 might be used.

The Hyperhidrosis Disease Severity Scale (1) is used by individuals to rate the severity of their symptoms on a scale of 1 to 4 (Table PG1):

Table PG1. The Hyperhidrosis Disease Severity Scale

Score	Definition
1	My underarm sweating is never noticeable and never interferes with my daily activities
2	My underarm sweating is tolerable but sometimes interferes with my daily activities
3	My underarm sweating is barely tolerable and frequently interferes with my daily activities
4	My underarm sweating is intolerable and always interferes with my daily activities

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, oral medications, botulinum toxin, and surgical procedures.

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 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, intradermal injections of botulinum toxin, endoscopic transthoracic sympathectomy, and surgical excision of axillary sweat glands. Treatment of secondary hyperhidrosis focuses on treatment of the underlying cause, such as discontinuing certain drugs or hormone replacement therapy as a treatment of menopausal symptoms.

Iontophoresis uses 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 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.

Botulinum toxin is a potent neurotoxin that blocks cholinergic nerve terminals; symptoms of botulism include cessation of sweating. Therefore, intracutaneous injections have been

investigated as a treatment of gustatory hyperhidrosis and focal primary hyperhidrosis, most frequently involving the axillae or palms. The drawback of this approach is the need for repeated injections, which have led some to consider surgical approaches.

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.

Subdermal laser treatment (2) is being studied as a treatment modality for axillary hyperhidrosis with the goal to target, heat, and destroy sweat glands, which are primarily found in a specific layer of tissue under the skin of the axilla. Tiny incisions (often so small they don't even require a stitch) are made in the underarms to allow the laser tool to be passed under the skin. The procedure usually takes less than an hour to complete.

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 effect. 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 (HDSS) (Table PG1) has had good correlation to other assessment tools and is practical in the clinical setting.

Regulatory Status

In 2004, botulinum toxin type A (Botox®; Allergan Pharmaceuticals, Ireland) was approved by the Food and Drug Administration (FDA) through the biologic license application (BLA) process for use to treat primary axillary hyperhidrosis (severe underarm sweating) that

cannot be managed by topical agents. In 2009, this product was renamed onabotulinumtoxinA. Other botulinum toxin products approved for non-cosmetic indications, but not specifically approved for treatment of hyperhidrosis, include:

- 2000: RimabotulinumtoxinB (Myobloc®, Solstice Neurosciences).
- 2009: AbobotulinumtoxinA (Dysport®, Medicis Pharmaceutical, Scottsdale, AZ).
- 2010: IncobotulinumtoxinA (Xeomin®, Merz Pharmaceuticals).
- 2022: DaxibotulinumtoxinA (Daxxify®; Revance Therapeutics).

In 2009, the FDA approved the following revisions to the prescribing information of botulinum toxin products:

- "A *Boxed Warning* highlighting the possibility of experiencing potentially life-threatening distant spread of toxin effect from injection site after local injection.
- A Risk Evaluation and Mitigation Strategy (REMS) that includes a *Medication Guide* to help patients understand the risk and benefits of botulinum toxin products.
- Changes to the established drug names to reinforce individual potencies and prevent medication errors. The potency units are specific to each botulinum toxin product, and the doses or units of biological activity cannot be compared or converted from one product to another botulinum toxin product. The new established names reinforce these differences and the lack of interchangeability among products." (3)

The REMS requirement for botulinum toxin products has been restored as of May 20, 2025. (4)

In 2011, the miraDry® System (Miramar Labs) was cleared for marketing by the FDA through the 510(k) process for treating primary axillary hyperhidrosis. (5) This microwave device is designed to heat tissue at the dermal-hypodermal interface, the location of the sweat glands. Treatment consists of 2 sessions for a total duration of approximately 1 hour. Sessions occur in a physician's office and local anesthetic is used. The device is not currently approved for the treatment of palmar or planter hyperhidrosis.

Rationale

This policy is based on a review of relevant professional guidelines and position statements.

Practice Guidelines and Position Statements

Society of Thoracic Surgeons

In 2011, the STS published an expert consensus statement on the surgical treatment of hyperhidrosis. (6) 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/m^2;
- No sweating during sleep;
- No significant comorbidities;
- Resting heart rate <55 beats per minute.

American Academy of Neurology

In 2008, the AAN issued guidelines on the use of botulinum toxin for the treatment of autonomic disorders and pain. (7) These guidelines were updated in 2013 and retired in 2017. (8) Table 1 summarizes the recommendations for botulinum toxin injection as a treatment of hyperhidrosis, by site and type of toxin.

Table 1. Recommendation Levels[a] by Hyperhidrosis Site and Botulinum Toxin Type

Botulinum Toxin	Axillary	Palmar	Gustatory
Botulinum neurotoxin type A	A	B	U
AbobotulinumtoxinA	B	U	U
IncobotulinumtoxinA	U	U	U
OnabotulinumtoxinA	B	U	U
RimabotulinumtoxinB	U	U	U

[a] A: established as effective, has at least 2 consistent Class I studies; B: probably effective, has at least 1 class I study or at least 2 consistent class II studies; C: possibly effective, has at least 1 class II study or at least 2 consistent class II studies; U: inadequate or conflicting data, treatment is unproven.

National Institute for Health and Care Excellence

In 2014, the NICE 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. (9)

The Institute also issued guidance in 2014 on endoscopic thoracic sympathectomy for primary hyperhidrosis of the upper limb. (10) 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."

For severe primary axillary hyperhidrosis, NICE issued guidance in 2017 on the use of transcutaneous microwave ablation. (11) The guidance stated that there is inadequate evidence in both quantity and quality to evaluate the safety and efficacy of microwave ablation.

International Hyperhidrosis Society (2)
The International Hyperhidrosis Society stated that laser treatment of underarm sweating is useful in that they can precisely target, heat, and destroy the sweat glands, which are primarily found in a specific layer of tissue under the skin of the underarms. The HIS algorithm does mention subdermal laser therapy but only after numerous other treatment have failed. The guidelines also state, "When approaching treatment to primary focal axillary hyperhidrosis, the general recommendation is to try more conservative therapy before resorting to invasive treatment."

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

Table 2. Summary of Key Trials

NCT Number	Trial Name	Planned Enrollment	Completion Date
Unpublished			
NCT03433859	Prospective Multicentric Open Randomised Controlled Trial Comparing Topical Aluminium Chloride to OnabotulinumtoxinA Intradermal Injections in Residual Limb Hyperhidrosis (Lower Limbs)	54	Mar 2021
NCT01930604	Botulinum Toxin Treatment in Craniofacial, Inguinal, Palmar, Plantar and Truncal Hyperhidrosis, a Randomized, Double Blind, Placebo Controlled Study	588	Oct 2019 (status unknown)
NCT03236012	Hyperhidrosis of the Residual Limb in Patients With Amputations: Developing a Treatment Approach	25	Feb 2022

Ongoing			
NCT03921320	Evaluation of Compensatory Sweating After Unilateral Videothoracoscopic Sympathectomy of the Dominant Side or Sequential Bilateral Videothoracoscopic Sympathectomy: a Multicentric Randomized Trial	200	Dec 2023 (unknown status)
NCT05737914	Bilateral Endoscopic Thoracic T3 Sympathectomy Versus T3 Radiofrequency Ablation for Treatment of Primary Palmar Hyperhidrosis	68	Oct 2023 (unknown status)

NCT: national clinical trial.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	11450, 11451, 32664, 64650, 64653, 64802, 64804, 64809, 64818, 64820, 64823, 69676, 97024, 97033
HCPCS Codes	E1399, J0585, J0586, J0587, J0588, J3490

*Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.

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Centers for Medicare and Medicaid Services

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at cms.hhs.gov.

Policy History/Revision	
Date	**Description of Change**
5/7/2026	New medical document. Treatment of hyperhidrosis may be considered medically necessary when criteria in Coverage are met.