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Reviewed: 08/27/26

Revised: 09/15/26

Subject: Treatment of Hyperhidrosis

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

Position Statement	Billing/Coding	Reimbursement	Program Exceptions	Definitions	Related Guidelines
Other	References	Updates			

DESCRIPTION:

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), head or face (craniofacial), or axillae (underarms).

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.

Summary and Analysis of Evidence: UpToDate review “Primary focal hyperhidrosis” (Smith, Pariser, 2024) states, “(a)lthough there are only limited data from randomized trials, iontophoresis appears to alleviate symptoms in approximately 85 percent of patients with palmar or plantar hyperhidrosis and is safe and simple to perform. Reductions in sweating are usually noted by the patient within two to four weeks when treatment is given three times per week. If tap water iontophoresis is ineffective, an anticholinergic agent may be added to the treatment tray. Potential side effects include dry, cracked hands (which can be relieved with moisturizers), skin erythema, skin discomfort, and transient vesiculation. Pretreatment application of petrolatum to the hands or feet may help to reduce risk for erythema and vesiculation. The biggest issue for patients with this treatment modality is generally the time required to perform the treatments. Initial treatment is generally 20 to 30 minutes per day or three times per week; however, the frequency of treatments can often be reduced after only 10 to 15 treatments. While some studies have found that a reduction in sweating can be maintained with therapy every two weeks, some patients find that shorter duration treatments three times a week are required for maintenance.” Ibrahim et al (2013) conducted the only randomized controlled trial of axillary suction-curettage in the treatment of hyperhidrosis. Each of 20 patients was randomized to receive botulinum toxin injections to one axilla and suction-curettage to the contralateral axilla. The primary outcome measure was reduction of sweat rate measured by gravimetry, and the secondary measure was quality of life as measured by a patient-directed questionnaire. At 3 months posttreatment, toxin injections decreased baseline resting sweat production by 72.1% versus 60.4% for suction-curettage, and baseline exercise-induced sweat production by 73.8% versus 58.8%. Compared with suction-curettage, toxin also resulted in greater improvements in quality of life by 0.80 points and 0.90 points at 3 and 6 months

posttreatment, respectively, as measured by the patient questionnaire. The authors concluded that “(b)y objective measures 3 months after treatment, neurotoxin injections are nominally more effective than suction-curettage in all cases, and markedly more effective in heavy sweaters. Patients have a very significant preference for neurotoxin injections at 3 months, and this is maintained at 6 months.” The remaining published literature on axillary liposuction consists of case reports (Tsai, Lin, 2001; Swinehart et al, 2000). A systematic review (Hsu et al, 2017) and RCT (Glaser et al, 2012) found a short-term benefit of microwave treatment in reducing hyperhidrosis but also reported skin-related adverse events (eg, pain, altered sensation). A case series (Hong et al, 2012) 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 are needed to confirm the efficacy of this treatment and better define the risk-benefit ratio. One nonrandomized comparative study (Purtuloglu et al, 2013) found RFA inferior to surgical sympathectomy for patients with severe bilateral palmar hyperhidrosis resistant to conservative treatment. Two small RCTs (Mostafa et al, 2019; Rummaneethorn et al, 2020) 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. 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 appropriately selected patients. (Tronstad et al, 2014; Hafner et al, 2002). Systematic reviews (Deng et al, 2011) and randomized controlled trials (Yuncu et al, 2013; Baumgartner et al, 2011) have supported the efficacy of endoscopic transthoracic sympathectomy at various levels for palmar, axillary, and craniofacial hyperhidrosis. These data are complemented by case series (Karamustafouglu et al, 2014; Andrade Filho et al, 2013) which have found high efficacy rates, but also high rates of compensatory sweating for these conditions. 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. Lima et al (2019) conducted a systematic review and meta-analysis of lumbar sympathectomy for plantar hyperhidrosis.37, 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. One RCT conducted among 30 women at a single center in Brazil (Loureiro et al, 2008) 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. Review articles have supported the use of tympanic neurectomy for patients with severe gustatory sweating. 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.

POSITION STATEMENT:

NOTE: For treatment of hyperhidrosis using botulinum toxin injections, please refer to MCG 09-J0000-29 Botulinum Toxin.

Primary focal hyperhidrosis

Treatment of primary focal hyperhidrosis **meets the definition of medical necessity** for any of the following 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 pharmacotherapy.

The following treatments **meet the definition of medical necessity** for treatment of primary **focal** hyperhidrosis:

- Surgical excision of axillary sweat glands, if conservative treatment with topical or systemic pharmacotherapy has failed
- Endoscopic transthoracic sympathectomy (ETS), if conservative treatment with topical or systemic pharmacotherapy has failed
- Iontophoresis.

Severe secondary gustatory hyperhidrosis

The following treatments for severe secondary gustatory hyperhidrosis **meet the definition of medical necessity**:

- Tympanic neurectomy if treatment with topical agents has failed.

The following treatments for hyperhidrosis are considered **experimental or investigational**:

- Axillary liposuction
- Microwave treatment
- Radiofrequency ablation
- Lumbar sympathectomy.

There is insufficient clinical evidence in the peer-reviewed literature to support conclusions regarding long-term safety, efficacy, or improvement in net health outcomes.

BILLING/CODING INFORMATION:

The following codes may be used to describe treatments for hyperhidrosis. There is no specific code describing surgical excision of the axillary sweat glands for hyperhidrosis.

CPT Coding:

32664	Thoracoscopy; with thoracic sympathectomy
64818	Sympathectomy, lumbar **(investigational *if performed for treatment of hyperhidrosis)**
69676	Tympanic neurectomy
97033	Iontophoresis, each 15 minutes

REIMBURSEMENT INFORMATION:

Refer to sections entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage products: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) was found at the time of the last guideline review date.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

DEFINITIONS:

Eccrine glands: any of the rather small sweat glands that produce a fluid secretion without removing cytoplasm from the secreting cells and that are restricted to the human skin (eccrine sweat gland).

Functional impairment: difficulties that substantially interfere with or limit role functioning in one or more major life activities (eg, may interfere with the ability to maintain appropriate hygiene, or may interfere with work in certain professions).

Gustatory: of or relating to the sense of taste. Gustatory hyperhidrosis conditions include Frey's syndrome, encephalitis, syringomyelia, diabetic neuropathies, herpes zoster parotitis and parotid abscess.

Iontophoresis: a technique that involves the use of an electric current to introduce various ions through the skin.

RELATED GUIDELINES:

Botulinum Toxins, 09-J0000-29

OTHER:

Index terms:

Endoscopic sympathectomy
Gustatory hyperhidrosis
Hyperhidrosis
Iontophoresis
Sweating, excessive
Sympathectomy, thoracic
Thoracoscopic sympathectomy

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 08/27/26.

GUIDELINE UPDATE INFORMATION:

04/15/03	New Medical Coverage Guideline.
05/15/04	Scheduled review; added coverage statement for surgical excision of sweat glands for axillary hyperhidrosis; added investigational statement for axillary liposuction.
04/15/06	Scheduled review; no change in coverage statement; added cross-reference statement regarding Botox injections for treating hyperhidrosis; removed aluminum chloride from the list of treatments discussed in this MCG; added “refractory to standard medical treatment” to the coverage statement in When Services Are Covered.
04/15/07	Scheduled review; no change in coverage statement.
06/15/07	Reformatted guideline.
04/15/08	Scheduled review; no change in position statement. Updated references.
04/15/09	Scheduled review. Update references and position statement with addition of indication for the use of Botox.
04/15/10	Annual review; investigational position statement for chemical or surgical lumbar sympathectomy added to guideline. References updated.
10/15/10	Revision; related ICD-10 codes added.
04/15/12	Scheduled review. Position statement maintained. Revised description section, ICD10 coding and definitions. Updated references.
04/15/13	Scheduled review. Revised description and position statement (designated microwave treatment for hyperhidrosis as experimental or investigational). Revised ICD9 coding, definitions and index terms. Updated references and reformatted guideline.
02/15/14	Revision; Program Exceptions section updated.
11/01/15	Revision: ICD-9 Codes deleted.
10/01/16	Revision: Billing/Coding Information section updated.
10/15/18	Scheduled review. Revised description and position statement. Updated programs exceptions and references.
09/15/20	Scheduled review. Revised description, position statement, and CPT coding. Updated references.
12/15/21	Scheduled review. Revised description, maintained position statement and updated references.
05/22/23	Update to Program Exceptions section.
11/15/23	Scheduled review. Maintained position statement and updated references.
09/15/24	Scheduled review. Revised description, added CPT 64818, maintained position statement and updated references.
09/15/25	Scheduled review. Maintained position statement and updated references.
09/15/26	Annual review: Position statements maintained; references updated.