Thoracic Sympathectomy for Hyperhidrosis

I. Description

Hyperhidrosis may be defined as excessive sweating beyond the level required to maintain normal body temperature in response to heat exposure or exercise.

Hyperhidrosis can be classified as either primary or secondary. Primary hyperhidrosis is idiopathic in nature, typically involving the hands (palmar), feet (plantar) or axillae. Secondary hyperhidrosis may be a side effect from taking certain drugs, such as tricyclic antidepressants or selective serotonin re-uptake inhibitors. It can also have underlying etiology such as febrile diseases, diabetes mellitus or menopause.

The consequences of hyperhidrosis are primarily psychosocial in nature. It may be socially embarrassing in such ways as limiting one's ability to comfortably shake hands with another person. Palmar hyperhidrosis may however, interfere with the ability to perform tasks integral to certain professions such as surgery, carpentry, music, art and others that require manual dexterity. Patients may require several changes of clothing a day and the condition may result in staining of the patient’s clothing or shoes.

A variety of treatments has been investigated for primary hyperhidrosis, including topical therapy with aluminum chloride, botulinum toxin and endoscopic transthoracic sympathectomy. In terms of botulinum toxin, this policy only discusses its use as a treatment of hyperhidrosis. Treatment of secondary hyperhidrosis focuses on treatment of any underlying causes.

II. Criteria/Guidelines

A. Treatment of patients with severe hyperhidrosis is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met
1. The patient has a documented history of debilitating hyperhidrosis that prevents him or her from performing essential activities of daily living and employment, or has any of the following medical complications:
   a. acrocyanosis of the hands; or
   b. history of recurrent skin maceration with bacterial or fungal infections; or
   c. history of recurrent secondary infections; or
   d. history of persistent eczematous dermatitis in spite of medical treatments with topical dermatological or systemic anticholinergic agents.
2. The patient has tried topical aluminum chloride or other extra-strength antiperspirants or absorbing powders and found them ineffective, or the patient’s use of such products resulted in a severe rash. The products must have been tried for a minimum of four weeks.
3. The patient is unresponsive to or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anti-cholinergics, beta-blockers or benzodiazepines) or botulinum toxin A (Botox).
   B. Where hyperhidrosis is secondary to a primary medical condition, that primary condition should be identified and treated wherever possible.

III. Limitations/Exclusions

For the majority of patients, treatment of primary hyperhidrosis will not meet HMSA’s payment determination criteria for medical appropriateness based on the lack of an essential functional impairment or medical complications associated with the condition. Treatment of hyperhidrosis for cosmetic reasons is not a benefit of HMSA plans and is therefore ineligible for coverage.

IV. Administrative Guidelines

A. Precertification is not required. HMSA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria.

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<th>CPT Code</th>
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<td>32664</td>
<td>Thoracoscopy, surgical; with thoracic sympathectomy</td>
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V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.
This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References