NO. 91451

HYPERHIDROSIS

Effective: 09/01/2026
Committee Review: 08/12/2026
Last Updated: 08/12/2026

Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Policy scope: This medical policy addresses treatments for hyperhidrosis.

Related policies:

- None identified.

I. MEDICAL NECESSITY CRITERIA

A. Inclusions: Treatment of intractable, disabling primary hyperhidrosis is medically necessary as described below:

1. **Botulinum toxins**: Reference the Drug Information page to view coverage details, including Preferred Agents.
2. **Tumescent liposuction** may be medically necessary for the treatment of primary axillary hyperhidrosis when the condition is refractory to conventional medical treatment, including an attempt at both topical and systemic pharmacotherapy (unless clinically contraindicated) and both (1) and (2) below are present:
   a. The condition is significantly interfering with the patient's ability to perform age-appropriate activities of daily living; and

b. The condition is causing persistent or chronic cutaneous conditions such as skin maceration, dermatitis, fungal infections and secondary microbial conditions.

3. **Sympathectomy** is considered medically necessary only when all of the following criteria are met:
   a. Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash.
   b. The patient is unresponsive or unable to tolerate prescribed pharmacotherapy, such as anticholinergics, beta-blockers, or benzodiazepines.
   c. Skin maceration with secondary infections or significant functional impairment which disrupts an individual's professional and/or social life

B. Exclusions

1. Surgical treatment of compensatory hyperhidrosis (the most common side effect of open or endoscopic sympathectomy) is considered not medically necessary.
2. Treatment of primary hyperhidrosis with iontophoresis (electrophoresis, Drionic device) is considered experimental/investigational and is therefore considered not medically necessary.
3. The following treatments are considered not medically necessary because they have not been proven to be effective for this indication:
   a. Psychotherapy
   b. Hypnosis
   c. Laser treatment (including subdermal Nd-YAG laser)
   d. Microwave therapy
   e. Percutaneous thoracic phenol sympathicolysis
   f. Sympathectomy where plantar hyperhidrosis is the only indication

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)

None identified	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	Botulinum Toxin Injections L39857 A59726 Outpatient Physical and Occupational Therapy Services L34049 A57067
First Coast Service Options, Inc.	Botulinum Toxins L33274 A57715
Wellpoint Federal (formerly National Government Services, Inc.)	Botulinum Toxin Injections L39832 A59707 Outpatient Physical and Occupational Therapy Services L33631 A56566
Noridian Healthcare Solutions	Botulinum Toxin Injections L35170 A57185
Novitas Solutions, Inc.	Botulinum Toxins L38809 A58423
Palmetto GBA	Botulinum Toxin Injections L39836 A59714 Home Health Occupational Therapy L34560 A53057 Outpatient Occupational Therapy L34427 A53064 Outpatient Physical Therapy L34428 A53065
WPS Insurance Corporation	Botulinum Toxin Injections L39909 A59809

III. BACKGROUND

Sweating is a natural phenomenon necessary for the regulation of an individual's body temperature. Hyperhidrosis, or excessive sweating, is a medical condition that is defined as sweating beyond what is necessary to maintain thermal regulation.

Hyperhidrosis is classified as primary or secondary, depending on its cause or origin. Primary hyperhidrosis, also known as essential or idiopathic hyperhidrosis, is caused by an overactive sympathetic nervous system. It can lead to intractable and profuse sweating in several locations of the body, including palms (hands), axillae (armpits), and plantar (feet). Secondary hyperhidrosis is the result of an underlying condition, such as Parkinson's disease, hyperthyroidism, diabetes mellitus, hyperpituitarism, pyrexia, hypoglycemia, or menopause. Secondary hyperhidrosis usually affects the whole body.

Regardless of the type or cause of hyperhidrosis, severe palmar hyperhidrosis can disrupt professional and social life and may lead to emotional problems. In the case of secondary hyperhidrosis, treatment of the underlying condition should first be attempted. In patients with disabling primary hyperhidrosis, a variety of treatment methods have been used.

The simplest method to control or reduce profuse sweating is the application of topical agents, such as aluminum chloride or other extra-strength chemical antiperspirants. Usually recommended as the first therapeutic measure, topical antiperspirants are effective in cases with light to moderate hyperhidrosis but have to be repeated regularly. Oral prescription medications commonly used include: anticholinergics, beta-blockers, and benzodiazepines.

Iontophoresis uses electric current to enhance drug penetration through the stratum corneum, the principal barrier to percutaneous absorption. Iontophoresis has been reported to provide temporary relief in mild cases of primary hyperhidrosis of the hands

and feet. The procedure has to be repeated regularly, initially in 20-minute sessions several times a week, gradually stretching out the interval between treatments to 1-2 weeks; however, treatments must be maintained indefinitely to control the symptoms of mild hyperhidrosis. The results vary: many find the electric current uncomfortable, the treatment expensive, time consuming, and the results not lasting long enough. The Drionic device (General Medical Co., Los Angeles, California) is an iontophoretic device that can be purchased for home use.

Hayes, Inc. conducted a Health Technology Assessment of tap water iontophoresis for the treatment of primary hyperhidrosis. Conclusions included:

- Overall, a very-low-quality body of evidence does not allow for conclusions regarding the efficacy of TWI for the treatment of primary hyperhidrosis. The overall quality rating was related to the lack of direct outcomes showing substantial clinical improvement in patients undergoing TWI, inadequate follow-up, and what appears to be short-lived effect.
- A systematic review and meta-analysis evaluated second-line therapies for the treatment of hyperhidrosis (Wade et al., 2017). The authors concluded that there was overall a very-low-quality body of evidence of benefit with tap water iontophoresis compared with placebo. The duration of effect was short-lived. The evidence for the comparative effectiveness of tap water iontophoresis compared with a combination of anticholinergic therapy and iontophoresis was inconclusive.
- Definitive patient selection criteria have not been established for the use of tap water iontophoresis for the treatment of primary hyperhidrosis in adult or pediatric populations.

In severe cases of intractable, disabling primary hyperhidrosis, surgical intervention has been utilized. The principle of sympathectomy is to interrupt the nerve tracks and nodes that transmit the signals to the sweat glands. Whether performed open or endoscopically, the most common side effect of surgery is compensatory hyperhidrosis characterized by a moderate increase in sweating in other parts of the body. A rare side effect is "gustatory sweating", a condition that leads to the sensation of sweating when eating.

Surgical removal of sweat glands has been shown to be only effective in the treatment of axillary hyperhidrosis, and may leave significant scarring. For a person suffering from primary hyperhidrosis, this approach is usually only a partial solution to the problem, especially since the most annoying areas usually are the hands.

Poor results have been reported with the use of psychotherapy and hypnosis. Psychological problems are in most cases a consequence of hyperhidrosis, not the cause. Hence, psychiatric or psychopharmacologic therapy cannot cure this disorder; at most it may help the patient to accept living with the problem.

Alternative medicine interventions, including homeopathy, massage, acupuncture and phytotherapeutic drugs, have not been proven effective.

For complete overview of standard treatment algorithms please refer to The International Hyperhidrosis Society at the following website: www.sweathelp.org

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
International Hyperhidrosis Society (IHhS)	Generalized hyperhidrosis Primary Focal Axillary Hyperhidrosis Primary Focal Craniofacial and Gustatory Hyperhidrosis (Frey's Syndrome) Primary Focal Palmar Primary Focal Plantar
American Academy of Dermatology Association (AAD)	Hyperhidrosis: Diagnosis and Treatment
National Institute for Health and Care Excellence (NICE)	Transcutaneous microwave ablation for severe primary axillary hyperhidrosis. HealthTech guidance. HTG458. December 20, 2017. Endoscopic thoracic sympathectomy for primary hyperhidrosis of the upper limb. HTG339. May 27, 2014.
Canadian Hyperhidrosis Advisory Committee (CHAC)	A comprehensive approach to the recognition, diagnosis, and severity-based treatment of focal hyperhidrosis: recommendations of the Canadian Hyperhidrosis Advisory Committee (Solish N et al., 2007)
Society of Thoracic Surgeons	The Society of Thoracic Surgeons expert consensus for the surgical treatment of hyperhidrosis (Cerfolio RJ et al., 2011)

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Product Code OUB: Instrument For Treatment Of Hyperhidrosis

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Decision date
miraDry System (Mirmar Labs, Inc.)	K180396 K160141 K150419 K131162 K103014	03/15/2018 10/31/2016 06/19/2015 10/25/2013 01/28/2011

VI. CODING

See also *Priority Health Medical Policy No. 91636 - Category III Current Procedural Terminology (CPT®) Codes ("T" codes)*

ICD-10 Codes that may support medical necessity

L74.510 Primary focal hyperhidrosis, axilla
L74.511 Primary focal hyperhidrosis, face
L74.512 Primary focal hyperhidrosis, palms
L74.513 Primary focal hyperhidrosis, soles
L74.519 Primary focal hyperhidrosis, unspecified
L74.52 Secondary focal hyperhidrosis
R61 Generalized hyperhidrosis

CPT/HCPCS Codes
Surgical and Medical procedures billed with the above diagnoses include but are not limited to:

15877 Suction assisted lipectomy; trunk
15878 Suction assisted lipectomy; upper extremity
15879 Suction assisted lipectomy; lower extremity

32664 Thoracoscopy, surgical; with thoracic sympathectomy
64650 Chemodenervation of eccrine glands; both axillae
64653 Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day
64804 Sympathectomy, cervicothoracic
64809 Sympathectomy, thoracolumbar

J0585 Injection, onabotulinum toxin A, 1 unit Botulinum toxin type A, per unit
J0586 Injection, abobotulinum toxin A, 5 units Injection, abobotulinum toxin A, 5 units
J0587 Injection, rimabotulinum toxin B, 100 units Botulinum toxin type B, per 100 units
J0588 Injection, incobotulinum toxin A, 1 unit
J0589 Injection, daxibotulinumtoxina-lanm, 1 unit

Not Medically Necessary for indications in this policy

17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
64999 Unlisted procedure, nervous system (when billed for phenol sympathicolysis; Explanatory notes must accompany claims billed with unlisted codes)

90832 Psychotherapy, 30 minutes with patient and/or family member
90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834 Psychotherapy, 45 minutes with patient and/or family member
90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

90837 Psychotherapy, 60 minutes with patient and/or family member
90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90880 Hypnotherapy

97024 Application of a modality to 1 or more areas; diathermy (eg, microwave)
97033 Application of a modality to one or more areas; iontophoresis, each 15 minutes
97810 Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811 Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)
97813 Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

97814 Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)

E1399 Durable medical equipment, miscellaneous for home iontophoresis unit *(Explanatory notes must accompany claim*)
17999 Unlisted procedure, skin, mucous membrane and subcutaneous membrane *(Explanatory notes must accompany claim)*

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.

- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

Guidelines

1. Cerfolio RJ, De Campos JR, Bryant AS, Connery CP, Miller DL, DeCamp MM, McKenna RJ, Krasna MJ. The Society of Thoracic Surgeons expert consensus for the surgical treatment of hyperhidrosis. Ann Thorac Surg. 2011 May;91(5):1642-8. doi: 10.1016/j.athoracsur.2011.01.105. PMID: 21524489.
2. Solish N, Bertucci V, Dansereau A, Hong HC, Lynde C, Lupin M, Smith KC, Storwick G; Canadian Hyperhidrosis Advisory Committee. A comprehensive approach to the recognition, diagnosis, and severity-based treatment of focal hyperhidrosis: recommendations of the Canadian Hyperhidrosis Advisory Committee. Dermatol Surg. 2007 Aug;33(8):908-23. doi: 10.1111/j.1524-4725.2007.33192.x. PMID: 17661933.

Additional references

3. Baumann LS, Helam ML. Botulinum toxin-B and the management of hyperhidrosis. Dermatology. 2004;22(1):60-65.
4. Bechara FG, Georgas D, Sand M, et al. Effects of a long-pulsed 800-nm diode laser on axillary hyperhidrosis: A randomized controlled half-side comparison study. Dermatol Surg. 2012;38(5):736-740.
5. Bejarano B, Manrique M. Thoracoscopic sympathectomy: A literature review. Neurocirugia (Astur). 2010;21(1):5-13.
6. Commons GW, Lim AF. Treatment of axillary hyperhidrosis/bromidrosis using VASER ultrasound. Aesthetic Plast Surg. 2009;33(3):312-323.
7. Dressler D, Saberi FA, Benecke R. Botulinum toxin type B for treatment of axillar hyperhidrosis. J Neurol. 2002;249(12):1729-1732.
8. Eisenach JH, Atkinson JL, Fealey RD. Hyperhidrosis: Evolving therapies for a well-established phenomenon. Mayo Clin Proc. 2005;80(5):657-666.
9. Felisberto G Jr, Maria Cataneo AJ, Cristina Cataneo D. Thoracic sympathectomy for the treatment of primary axillary hyperhidrosis: systematic review and proportional meta-analysis. Ann Med. 2021 Dec;53(1):1216-1226. doi: 10.1080/07853890.2021.1953126. PMID: 34282698; PMCID: PMC8293952.
10. Hayes, Inc. Evidence Analysis Research Brief. Tap Water Iontophoresis for Treatment of Hyperhidrosis. Hayes, Inc. March 10, 2025.

11. Hayes, Inc. Evolving Evidence Review. miraDry Microwave Therapy (miraDry Inc.) for Management of Primary Axillary Hyperhidrosis. Hayes, Inc. November 16, 2023 (Annual Review November 6, 2026).
12. Hayes, Inc. Health Technology Assessment. Endoscopic Sympathectomy Treatment of Hyperhidrosis. Hayes, Inc. January 14, 2003 (Annual Review February 15, 2008).
13. Hayes, Inc. Health Technology Assessment. Tap Water Iontoporesis for the Treatment of Primary Hyperhidrosis. Hayes, Inc. April 27, 2018 (Annual Review June 15, 2020).
14. Hong HC, Lupin M, O'Shaughnessy KF. Clinical evaluation of a microwave device for treating axillary hyperhidrosis. Dermatol Surg. 2012;38(5):728-735.
15. Glaser DA. The use of botulinum toxins to treat hyperhidrosis and gustatory sweating syndrome. Neurotox Res. 2006;9(2-3):173-177.
16. Glaser DA, Coleman WP 3rd, Fan LK, et al. A randomized, blinded clinical evaluation of a novel microwave device for treating axillary hyperhidrosis: The dermatologic reduction in underarm perspiration study. Dermatol Surg. 2012;38(2):185-191.
17. Glogau RG. Topically applied botulinum toxin type A for the treatment of primary axillary hyperhidrosis: Results of a randomized, blinded, vehicle-controlled study. Dermatol Surg. 2007;33(1 Spec No.):S76-S80.
18. Goldman A, Wollina U. Subdermal Nd-YAG laser for axillary hyperhidrosis. Dermatol Surg. 2008;34(6):756-762
19. Hoorens I, Ongenae K. Primary focal hyperhidrosis: Current treatment options and a step-by-step approach. J Eur Acad Dermatol Venereol. 2012;26(1):1-8
20. Kao TH, Pan HC, Sun MH, et al. Upper thoracic sympathectomy for axillary osmidrosis or bromidrosis. J Clin Neurosci. 2004;11(7):719-722.
21. Kim WO, Kil HK, Yoon KB, et al. Influence of T3 or T4 sympathicotomy for palmar hyperhidrosis. Am J Surg. 2010;199(2):166-169.
22. Letada PR, Landers JT, Uebelhoer NS, Shumaker PR. Treatment of focal axillary hyperhidrosis using a long-pulsed Nd:YAG 1064 nm laser at hair reduction settings. J Drugs Dermatol. 2012; 11(1):59-63.
23. Licht PB, Ladegaard L, Pilegaard HK. Thoracoscopic sympathectomy for isolated facial blushing. Ann Thorac Surg. 2006;81(5):1863-1866.
24. Licht PB, Pilegaard HK. Severity of compensatory sweating after thoracoscopic sympathectomy. Ann Thorac Surg. 2004;78(2):427-431.
25. Lowe NJ, Glaser DA, Eadie N, et al; North American Botox in Primary Axillary Hyperhidrosis Clinical Study Group. Botulinum toxin type A in the treatment of primary axillary hyperhidrosis: A 52-week multicenter double-blind, randomized, placebo-controlled study of efficacy and safety. J Am Acad Dermatol. 2007;56(4):604-611
26. Malmivaara A, Kuukasjarvi P, Autti-Ramo I, et al. Effectiveness and safety of endoscopic thoracic sympathectomy for excessive sweating and facial blushing: A systematic review. Int J Technol Assess Health Care. 2007;2391):54-62.
27. McConaghy JR, Fosselman D. Hyperhidrosis: Management Options. Am Fam Physician. 2018 Jun 1;97(11):729-734. PMID: 30215934.
28. Moniati F, Vassiliou M, Costa C, Chatzimatthaiou C, Chatzimatthaiou M. Efficacy and Safety of Treatments for Primary Palmar Hyperhidrosis: A Systematic Review Assessing Patient-Centric Outcomes. Dermatol Res Pract. 2025 Aug 20;2025:8867838. doi: 10.1155/drp/8867838. PMID: 40881604; PMCID: PMC12390518.
29. Paller AS, Shah PR, Silverio AM, et al. Oral glycopyrrolate as second-line treatment for primary pediatric hyperhidrosis. J Am Acad Dermatol. 2012;67(5):918-923.

30. Seo SH, Jang BS, Oh CK, et al. Tumescent superficial liposuction with curettage for treatment of axillary bromhidrosis. J Eur Acad Dermatol Venereol. 2008;22(1):30-35.
31. Smith CC. Primary focal hyperhidrosis: Management. In: UpToDate, connor RF (Ed), Wolters Kluwer. (Accessed on June 10, 2026)
32. Solish N, Bertucci V, Dansereau A, et al.; Canadian Hyperhidrosis Advisory Committee. A comprehensive approach to the recognition, diagnosis, and severity-based treatment of focal hyperhidrosis: Recommendations of the Canadian Hyperhidrosis Advisory Committee. Dermatol Surg. 2007;33(8):908-923.
33. Streker M, Reuther T, Verst S, Kerscher M. Axillary hyperhidrosis -- efficacy and tolerability of an aluminum chloride antiperspirant. Prospective evaluation on 20 patients with idiopathic axillary hyperhidrosis. Hautarzt. 2010;61(2):139-144.
34. Talarico-Filho S, Mendonca DO Nascimento M, Sperandeo DE Macedo F, DE Sanctis Pecora C. A double-blind, randomized, comparative study of two type A botulinum toxins in the treatment of primary axillary hyperhidrosis. Dermatol Surg. 2007;33(1 Spec No.):S44-S50.
35. Walling HW. Systemic therapy for primary hyperhidrosis: A retrospective study of 59 patients treated with glycopyrrolate or clonidine. J Am Acad Dermatol. 2012r;66(3):387-392.
36. Wang YC, Wei SH, Sun MH, Lin CW. A new mode of percutaneous upper thoracic phenol sympathicolysis: Report of 50 cases. Neurosurgery. 2001;49(3):628-634.
37. Wei Y, Xu ZD, Li H. Quality of life after thoracic sympathectomy for palmar hyperhidrosis: a meta-analysis. Gen Thorac Cardiovasc Surg. 2020 Aug;68(8):746-753. doi: 10.1007/s11748-020-01376-5. Epub 2020 May 10. PMID: 32390086.
38. Wollina U, Köstler E, Schönlebe J, Haroske G. Tumescent suction curettage versus minimal skin resection with subcutaneous curettage of sweat glands in axillary hyperhidrosis. Dermatol Surg. 2008;34(5):709-716.
39. Wolosker N, de Campos JR, Kauffman P, Puech-Leão P. A randomized placebo-controlled trial of oxybutynin for the initial treatment of palmar and axillary hyperhidrosis. J Vasc Surg. 2012;55(6):1696-1700.

SUMMARY OF CHANGES

Deletions:

- I. A.: Deleted names of botulinum toxin preferred agents (link is sufficient).
- I. B.: Deleted details of benefits as these are addressed outside of medical policy.

Past committee review dates: 08/2002, 08/2003, 07/2004, 07/2005, 04/2006, 04/2007, 10/2007, 04/2008, 04/2010, 04/2011, 04/2012, 04/2013, 05/2014, 05/2015, 05/2016, 05/2017, 05/2018, 05/2019, 05/2020, 05/2021, 05/2022, 05/2023, 05/2024, 08/2024, 08/2025.

AMA CPT Copyright Statement: All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.