Incorporating Diagnosis and Treatment of Hyperhidrosis into Clinical Practice

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KEYWORDS

• Primary focal hyperhidrosis • Medical necessity • Diagnosis • Reimbursement

KEY POINTS

- Treatments for hyperhidrosis lead to a great improvement in patient quality of life.
- Proper billing and coding are needed to document diagnosis and treatment and assure proper reimbursement.
- Providers may buy and bill botulinum toxin or prescribe it as a drug for any individual patient.
- Algorithms for treating various forms of hyperhidrosis can help clinicians decide on the best treatments.

Is hyperhidrosis a cosmetic condition for which patients should pay out of pocket for treatment or is it a true medical disease that should be considered necessary to treat and therefore covered by health insurance? How this question is answered by the provider will largely determine how treatments are incorporated into a busy clinical practice.

For providers who choose to treat hyperhidrosis as a cosmetic condition, the provider need not bother with insurance precertification, determination of medical necessity, or billing. Whether the patient is getting iontophoresis, botulinum toxin injections, local surgery, or treatment with a device such as the miraDry microwave system (Miramar Labs, Inc., Santa Clara, CA, USA), the provider simply collects a cash payment from the patient, often before the procedure is performed.

By considering hyperhidrosis a true disease that is medically necessary to treat, the financial barrier to care is lessened and far more people with the condition are able to receive treatment. Expensive treatments such as botulinum toxin injections or miraDry procedures are inaccessible for many patients if out-of-pocket payment is required. Some high-deductible health plans also present an obstacle to care if these deductibles have not been met already, which is often the case for an otherwise healthy young person with low health care expenses—the primary demographic of patients with hyperhidrosis. Curiously, the medical necessity of one of the most expensive and most invasive treatments, endoscopic thoracic sympathectomy, is seldom questioned by insurance payers and is usually covered.

If the full range of hyperhidrosis treatments is made available, including topical and systemic therapies, iontophoresis, botulinum toxin injections, miraDry microwave procedures, and local surgery, the provider should get to know the coverage policies of the major health plans in the local service area. Some plans will require a stepwise ladder of treatments; usually failure of or intolerance to topical and oral systemic therapies is required before other treatments, such as iontophoresis or botulinum toxin injections, will be considered for

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coverage. Treatment with the miraDry microwave device is uniformly not covered by insurance.

Contacting a medical director of the major health plans in a provider's local service area may be helpful to ascertain whether the health plan uses any particular criteria to determine medical necessity or follows guidelines for clinical decision making regarding coverage of treatments for hyperhidrosis. One example of an ill-conceived criterion of medical necessity is the requirement that a patient exhibit signs of maceration or infection before axillary hyperhidrosis is considered medically necessary to treat, when in fact maceration and infection are seldom seen in uncomplicated primary focal axillary hyperhidrosis. If a health plan does not have criteria for determining the medical necessity for treatment of hyperhidrosis, providers can offer to help develop them. Health plans pay attention to published literature, especially that which is peer-reviewed and presents good science. Published treatment algorithms, such as those developed by the International Hyperhidrosis Society (see **Figs. 2–7**), may be a helpful resource when developing a carrier's precertification process.

A letter of medical necessity is usually required to document the need for treatment of hyperhidrosis for any individual patient. Items that should be in this letter include the severity of the disorder, examples of professional or psychosocial disability or impairment, and a history of previous treatments. Severity may be documented on the Hyperhidrosis Disease Severity Scale (HDSS), a validated patient-reported metric that is used in most clinical trials of hyperhidrosis treatments. The HDSS is described in more detail in the article by Pariser and Ballard elsewhere in this issue. Documenting a specific incident of extreme embarrassment or an example when the disorder prevented or ruined a social or professional encounter can be compelling. If failure of a previous treatment is required before a patient can advance to a more expensive or invasive one, it is important to have reasonable periods for the "failed" treatments. For example, it is not reasonable to require failure of a topical or systemic treatment for a period of 6 months if the agent is clearly not producing a satisfactory result or is not being adequately tolerated.

BEST PRACTICES FOR PATIENT FLOW

When a patient calls for an appointment and excessive sweating is identified as the reason for the visit, the patient should be referred to a source of authoritative information, such as the International Hyperhidrosis Society Web site (sweathelp.org). Office visits can be much more productive when patients become informed beforehand.

Providers should have an intake form that can be sent to the patient in advance or completed at the time of the visit to capture information such as past medical history relating to the sweating, HDSS score (described in the article by Pariser and Ballard elsewhere in this issue), and previous treatment history.

Nonphysician clinicians, such as nurse practitioners, physician assistants, and medical assistants, can be a great help in aspects of initial evaluation and diagnosis, formulating a treatment plan, prescribing topical and systemic agents, performing iontophoresis and microwave treatments, and administering botulinum toxin injections. The specific tasks assigned to the nonphysician clinicians should be commensurate with their licensure and conform to training and supervision requirements of state law and standard of medical care. Everyone on the care team can participate in patient education about the disease and its treatments.

Providers should use resources such as the International Hyperhidrosis Society Web which has physician and patient educational material as well as administrative support. Manufacturers of some of the drugs and devices used to treat hyperhidrosis also have patient and provider support material (see the article by Pieretti elsewhere in this issue).

BILLING AND CODING FOR HYPERHIDROSIS AND ITS TREATMENTS

Proper billing and coding for hyperhidrosis diagnosis and treatments will ensure that the condition is reported properly and the provider is appropriately reimbursed. Proper coding involves the use of an ICD-9 (*International Classification of Diseases, Ninth Revision*) code for the diagnosis, a CPT (*Current Procedural Terminology*) code for the procedure performed, and, if applicable, an HCPCS (Healthcare Common Procedure Coding System) drug code (commonly called a *J code*), which is used to identify injectable drugs such as botulinum toxin.

ICD-9 Codes

The ICD-9 codes are used to document the diagnosis. Most patients who have excessive sweating from one or more body sites and are diagnosed with primary focal hyperhidrosis are appropriately coded with the ICD-9 code 705.21. If there is a primary cause for the hyperhidrosis, such as a medication, endocrinopathy, or neurologic issue, the IDC-9 code for secondary hyperhidrosis is used, which is 705.22.

ICD-10 Codes

Scheduled to be implemented in October, 2015, after a year delay, diagnosis codes using ICD-10 will preplace ICD-9 in the United States. These codes will be more specific than the ICD-9 codes and will more properly describe the diagnosis (**Fig. 1**).

CPT Codes

Iontophoresis

The primary CPT code for iontophoresis treatments is 97033, which is defined as, "Iontophoresis, each 15 minutes." Depending on how many body areas are treated, usually more than one unit of 97033 will be billed. The standard treatment time for iontophoresis is usually 20 minutes to each body part, with the polarity of the current reversed after the first 10 minutes. Treatments to both hands, both feet, or one hand and one foot for 20 minutes generates 2 billing units of code 97033. Treatment of all 4 extremities should take 40 minutes of iontophoresis and would generate 3 billing units of 97033. If any separately identifiable service is also provided, such as a physician visit for evaluation of treatment progress, it is appropriate to also use a code for evaluation and management (E&M) services (CPT codes 99211–99213), depending on the intensity of the service rendered. In this case, when an E&M service is being provided on the same day as the iontophoresis, the modifier "−25" should be appended to the E&M code to indicate that it was a separately identifiable service.

Botulinum toxin injections

Two specific CPT codes are used for botulinum toxin injections, one for the axillae and one for the scalp, face, and/or neck. Injections into other areas on the extremities, including the hands and feet, are properly reported with CPT code 64999, which is defined as, "Unlisted procedure, nervous system." Use of the 64999 code usually requires manual processing and often requires written medical documentation. There is usually no predetermined value for the 64999 code. The code for axillary injections is 64650 and is properly used when one or both axillae are injected. CPT code 64653 applies to injections in any area on face, scalp, or neck, and only one unit of this code may be billed per day.

HCPCS J Codes

The J code J0585, "Injection, onabotulinumtoxinA, 1 unit," is used to report the physician-supplied botulinum toxin of the Botox brand, the only botulinum toxin approved by the US Food and Drug Administration (FDA) for the treatment of hyperhidrosis. The J0585 code only applies to *1 unit* of botulinum toxin. Because 100 units are usually used and for axillae and up to 300 units may be used at one treatment for other areas, such as hands and feet, it is important to bill with the appropriate number of billing units of the J code.

BILLING OPTIONS FOR BOTULINUM TOXIN TREATMENTS

Botulinum toxin injections may be provided to patients in 2 ways if the procedure and the cost of the drug will be covered by insurance. Either the practice can buy the drug and bill the patient's insurance ("buy-and-bill") or the botulinum toxin can be written as a prescription.

In the buy-and-bill model, the provider purchases the botulinum toxin and performs the injections, and bills both the CPT code for the injection services and the J code for the botulinum toxin. Usually a preauthorization process is required before the injections are administered to assure payment. Medical necessity will need to be documented, but different insurance payers will have

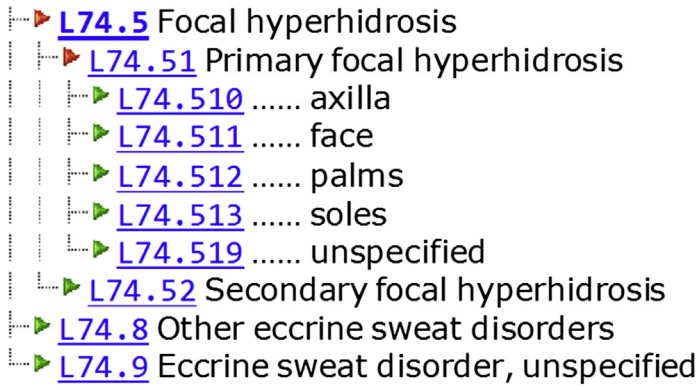

Fig. 1. ICD-10 codes for hyperhidrosis effective in October, 2015.

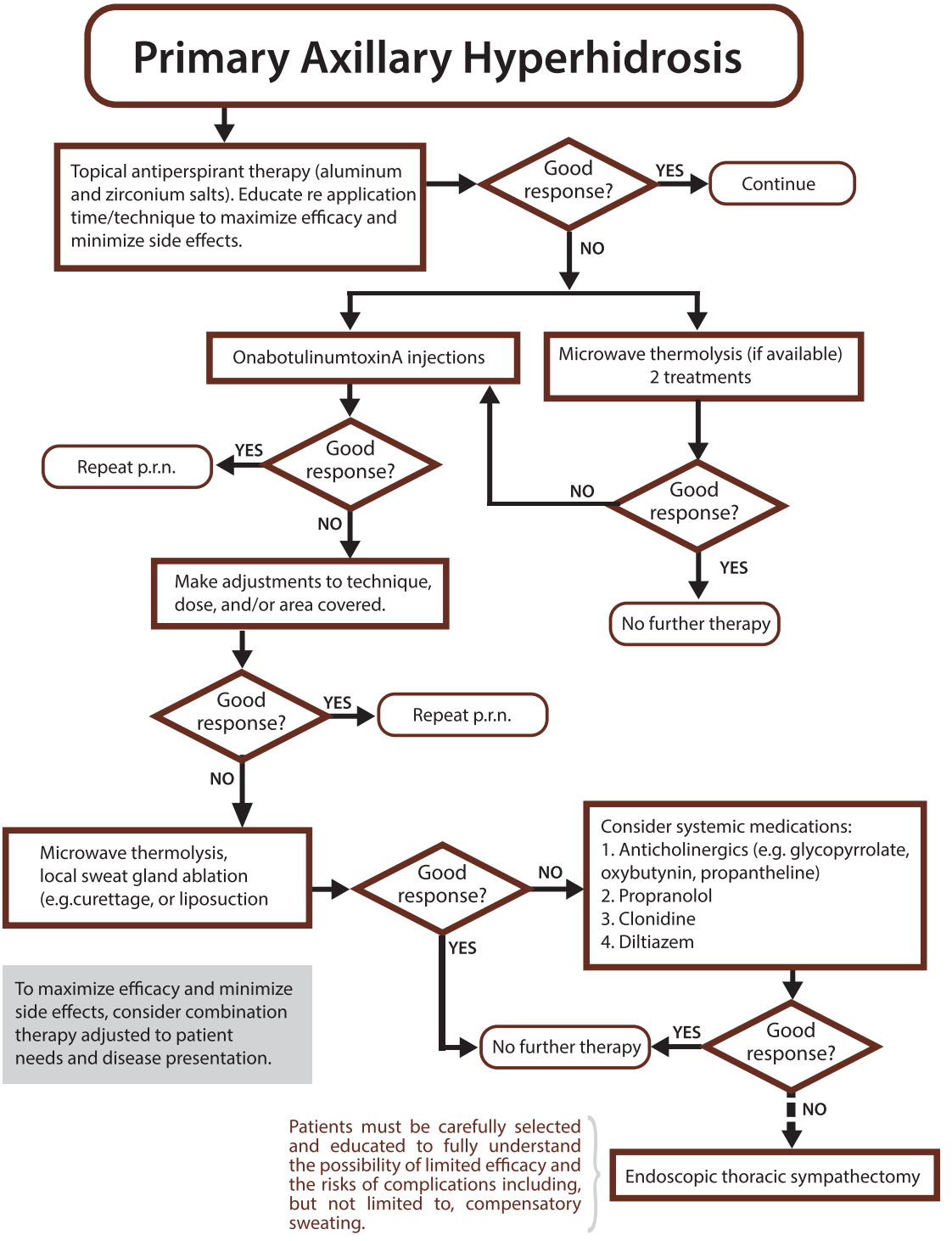

Fig. 2. Algorithm for treatment of primary axillary hyperhidrosis. (*Courtesy of* International Hyperhidrosis Society, Quakertown, PA; with permission.)

different rules about determination of medical necessity. Providers should become familiar with the preauthorization procedures of the various companies to ease the process. Providers should also be aware that preauthorization does not always guarantee payment. Treatments may be preauthorized as a covered service on the health plan, but the insurance carrier may determine

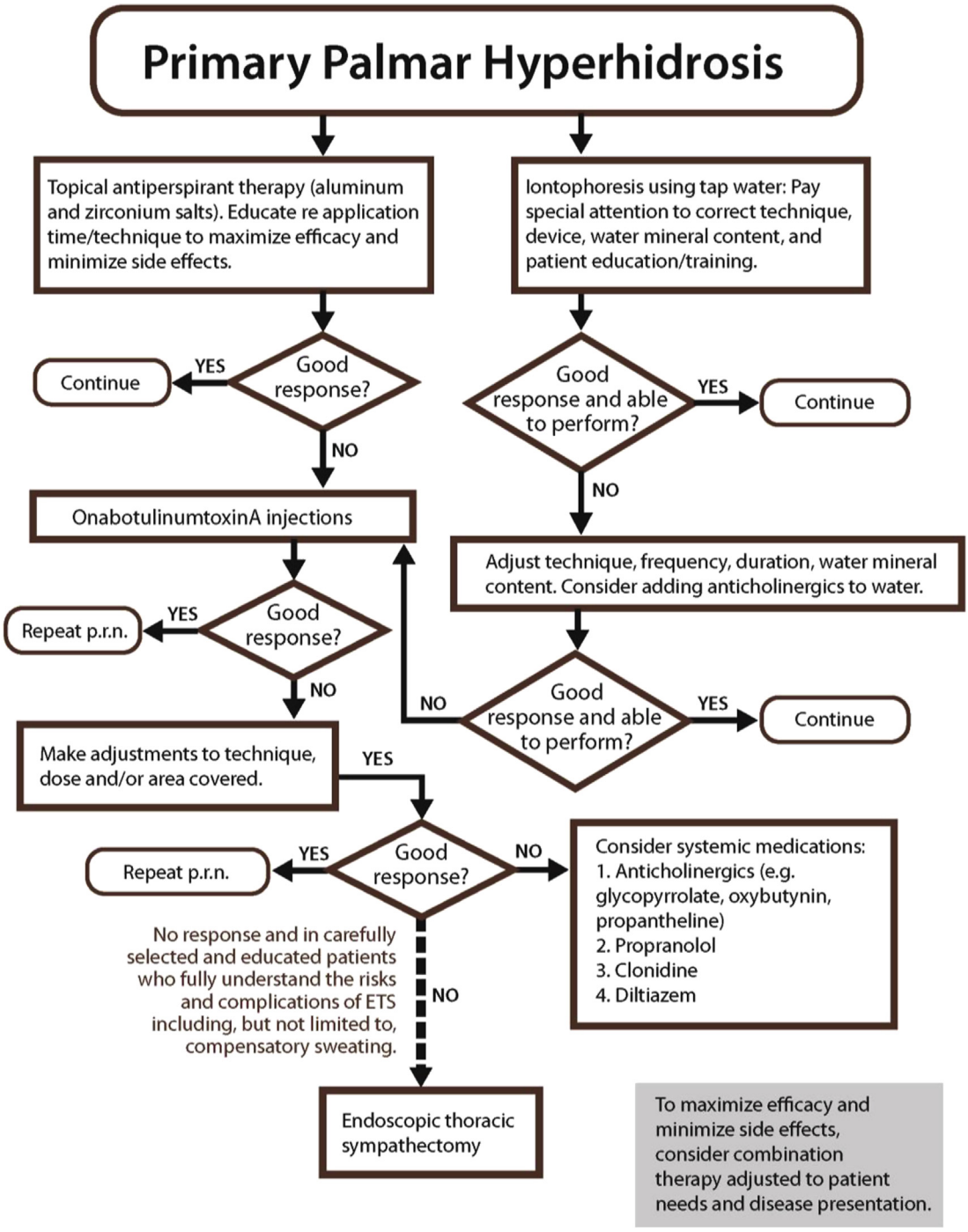

Fig. 3. Algorithm for treatment of primary palmar hyperhidrosis. (*Courtesy of* International Hyperhidrosis Society, Quakertown, PA; with permission.)

retrospectively that a particular treatment for a particular patient was not medically necessary. In this case, the provider may have to appeal the denial of a claim, and may eventually have to absorb the cost of the botulinum toxin, which is usually more than the physician service. Because botulinum toxin provided to the patient on the buy-and-bill method is considered a medical benefit (as opposed to a pharmacy benefit), the patient may have less of a copay, but that is highly

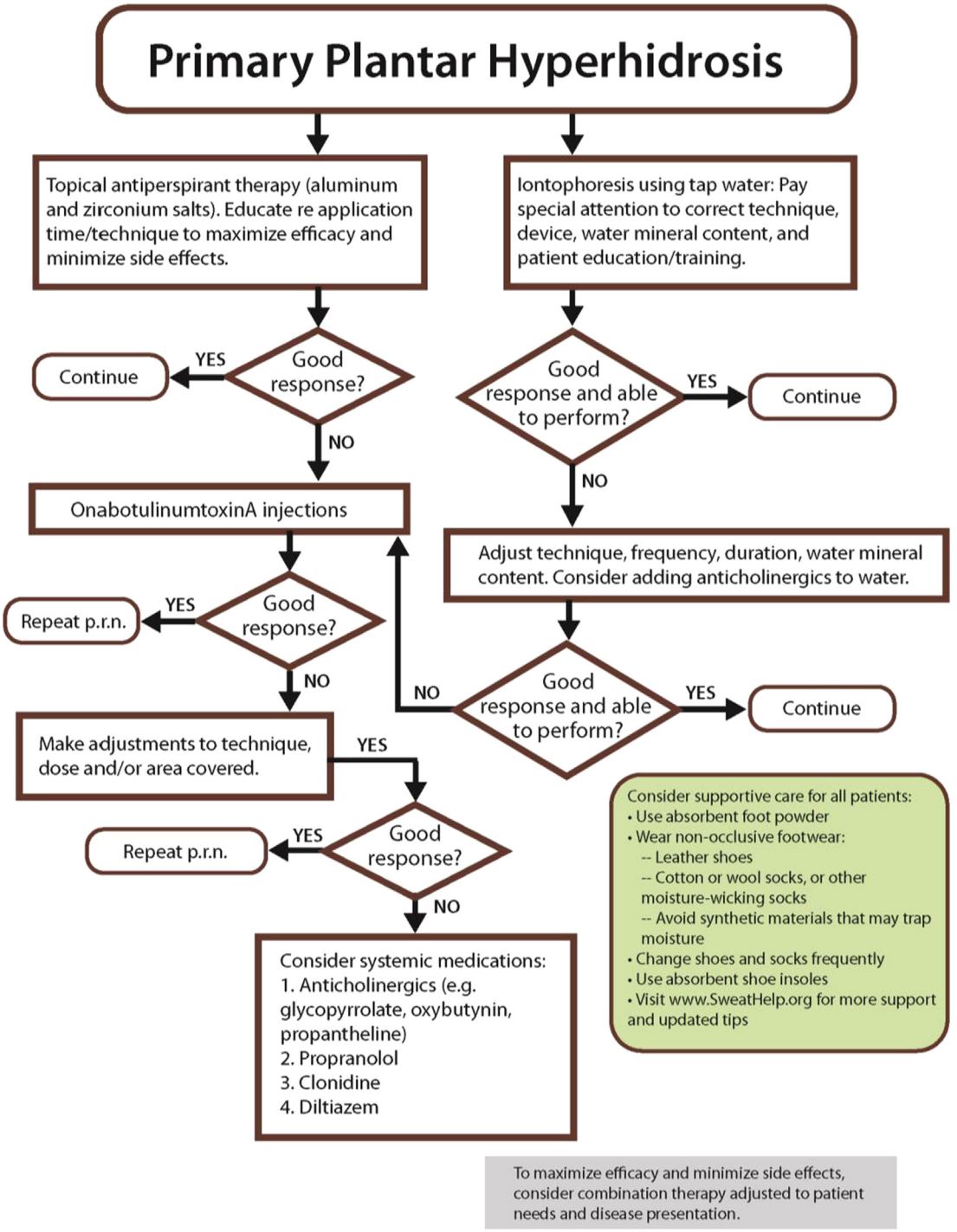

Fig. 4. Algorithm for treatment of primary plantar hyperhidrosis. (*Courtesy of* International Hyperhidrosis Society, Quakertown, PA; with permission.)

variable depending on the terms of a patient's individual health plan coverage.

The other billing option for the provider is to prescribe the botulinum toxin for the individual patient. A written or electronic prescription is sent to the patient's pharmacy, which is often a mail-order specialty pharmacy directed by the health plan, but also could be a local retail pharmacy. In this case,

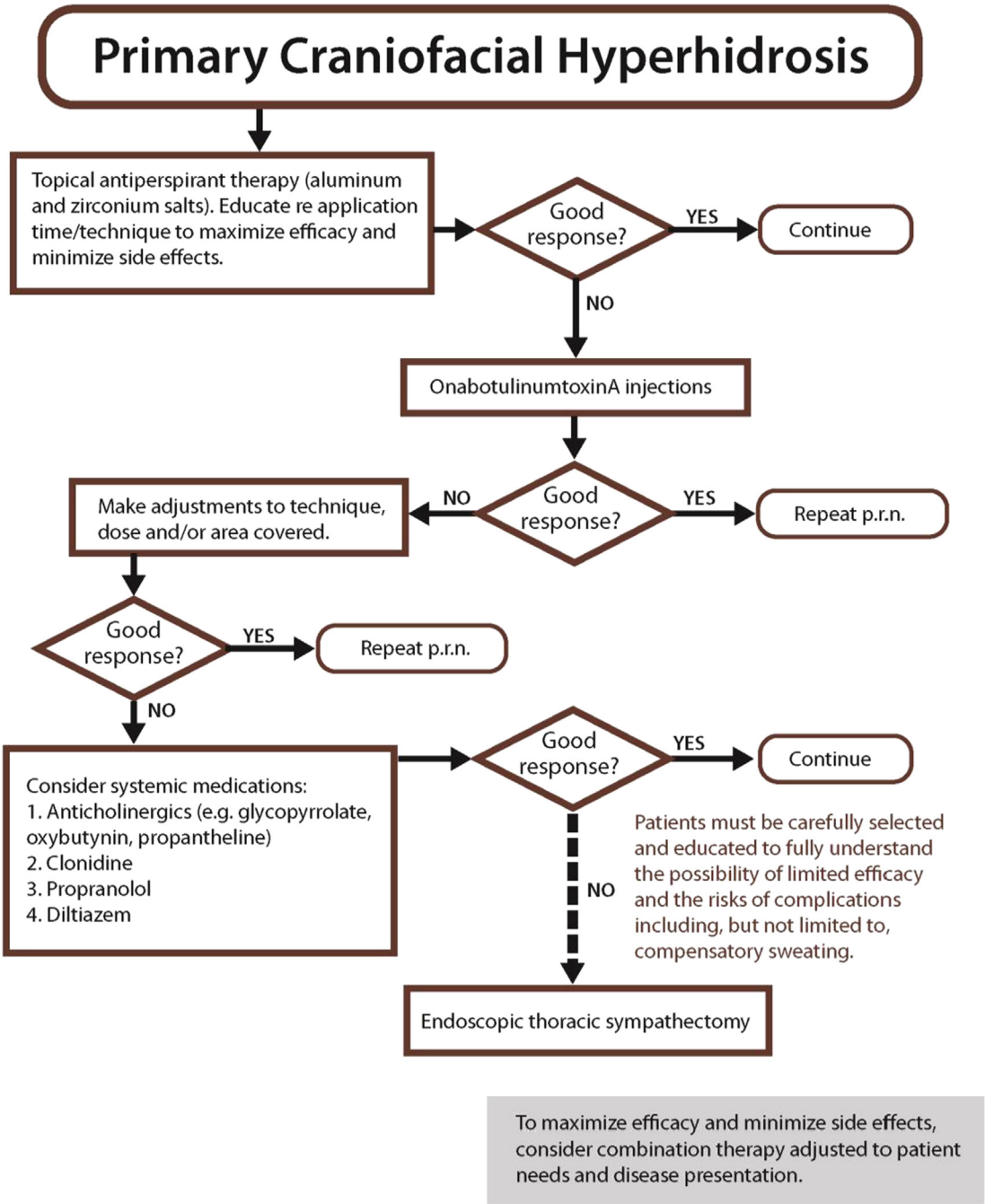

Fig. 5. Algorithm for treatment of primary craniofacial hyperhidrosis. (*Courtesy of* International Hyperhidrosis Society, Quakertown, PA; with permission.)

the pharmacy is responsible for obtaining the necessary preauthorization for the drug. The pharmacy then provides the botulinum toxin to the provider, who administers it in the office. The provider should still obtain preauthorization for the injection service, and should bill using the proper CPT code for the anatomic area being treated. This method of billing does not put the provider at risk for the cost of the botulinum toxin. The patient will be responsible for a copay for the drug, and for the injection service. The copay will vary according to the terms of the patient's individual policy.

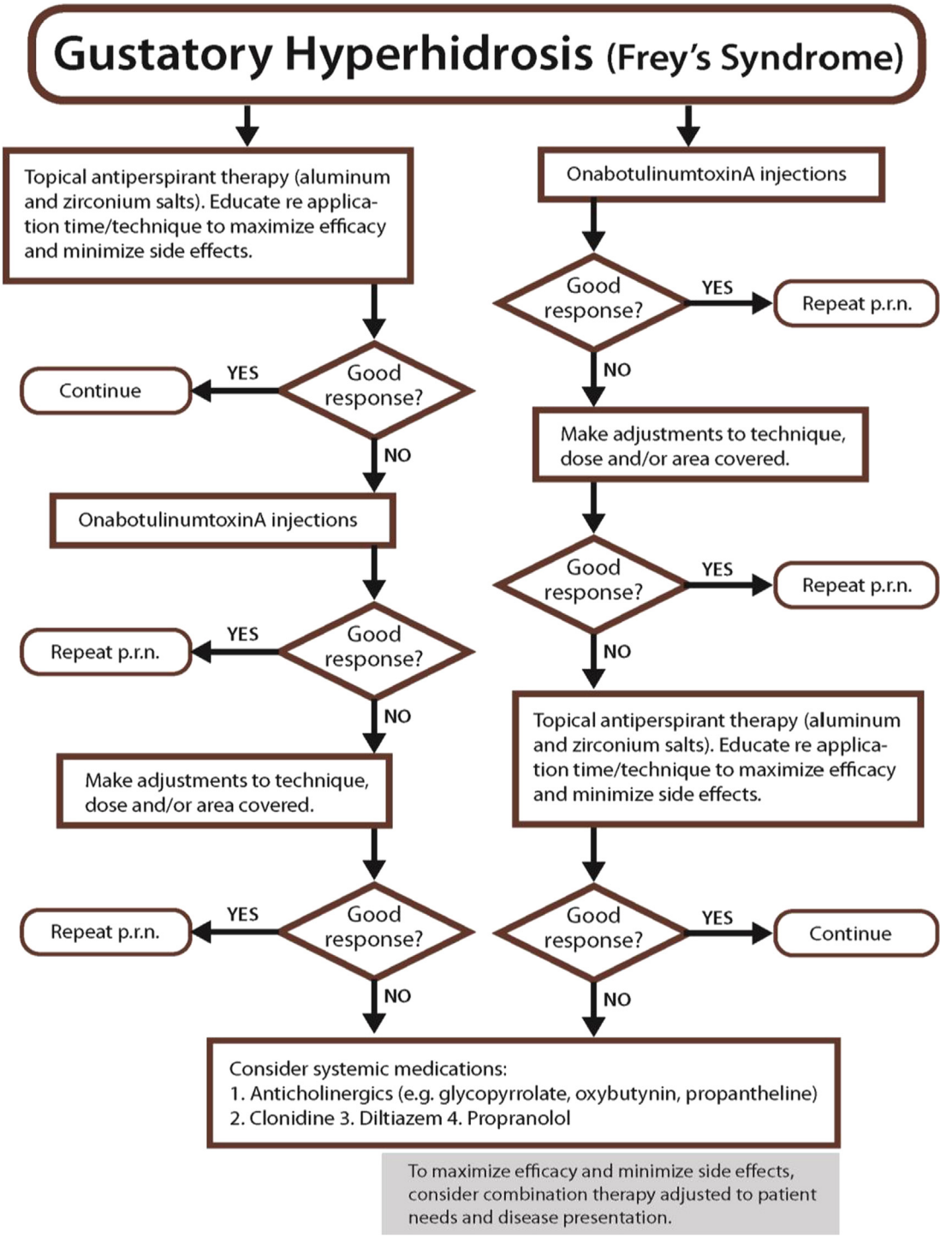

Fig. 6. Algorithm for treatment of gustatory hyperhidrosis (Frey syndrome). (*Courtesy of* International Hyperhidrosis Society, Quakertown, PA; with permission.)

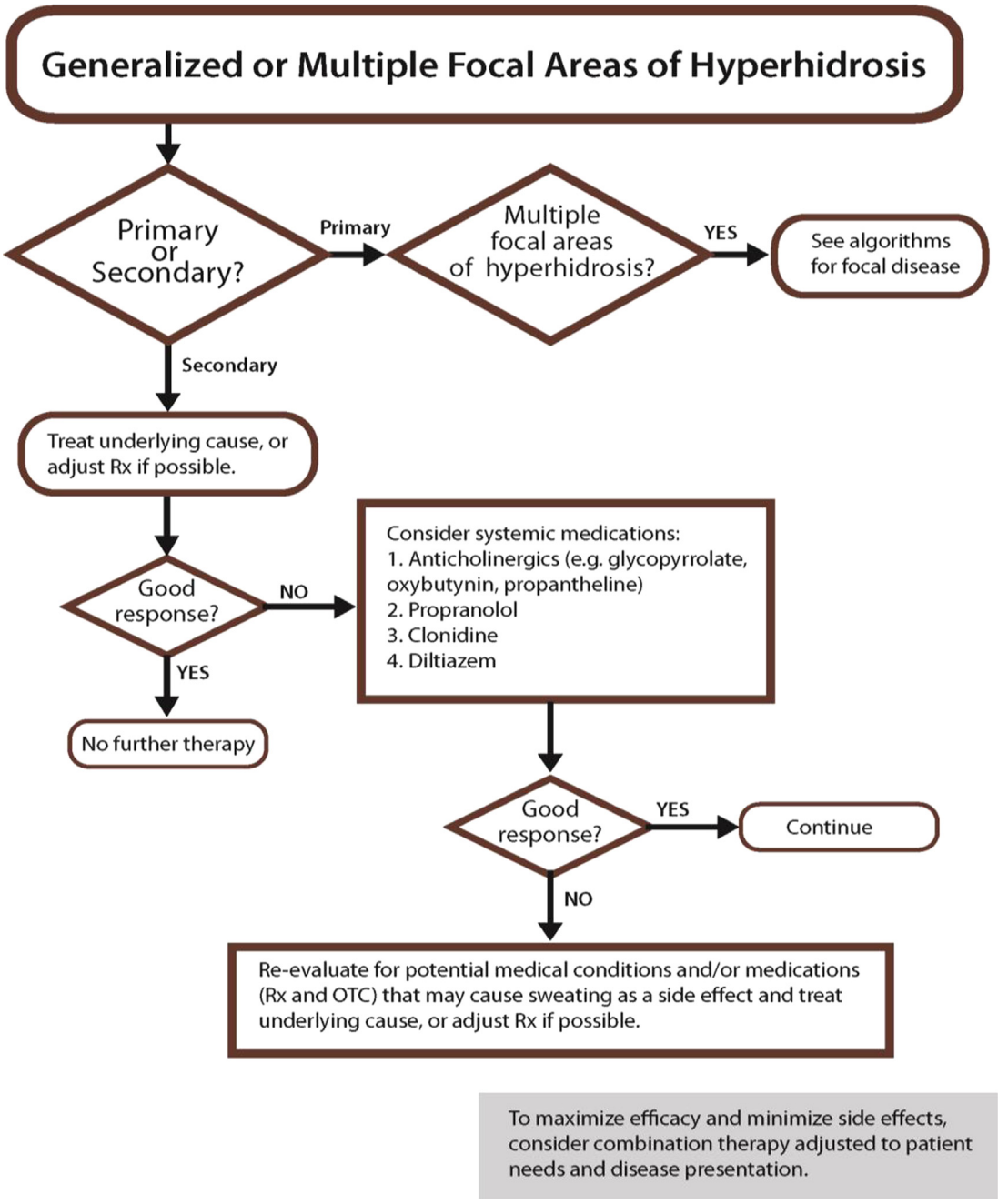

Fig. 7. Algorithm for treatment of generalized or multiple focal areas of hyperhidrosis. (*Courtesy of* International Hyperhidrosis Society, Quakertown, PA; with permission.)

BILLING FOR OTHER SERVICES RELATING TO HYPERHIDROSIS TREATMENTS

The starch-iodine test for determining the extent of excessive sweating in any particular area is described in the article by Trindade de Almieda elsewhere in this issue. No CPT code exists for this procedure, and usually no additional reimbursement is provided for this procedure. It is considered part of the service covered by CPT codes 64650 and 64653.

Local surgical procedures for the treatment of axillary hyperhidrosis, such as liposuction, subcutaneous curettage, and laser treatments, are also

not described by any CPT code and are seldom reimbursed by insurance.

Similarly, although miraDry microwave treatments are approved by the FDA for axillary hyperhidrosis, they have no associated CPT code and are usually not covered by insurance. Some patients may try to obtain reimbursement on their own.

SUMMARY

Treatment of primary focal hyperhidrosis is easily learned and can greatly improve the quality of life of patients with this disease. Patients with successfully treated hyperhidrosis often become loyal and supportive spokespersons. Through the development of efficient office management procedures, the diagnosis and treatment of these patients can be easily integrated into office practice and be economically viable for a busy dermatologic practice. Properly trained and supervised nonphysician clinicians, such as nurse practitioners, physician assistants, and medical assistants, can greatly enhance efficiency through providing most of the treatments, patient education, and follow-up for hyperhidrosis, allowing physicians to concentrate on diagnosis and treatment planning.

To help providers with therapeutic decision making for patients with hyperhidrosis, the International Hyperhidrosis Society published algorithms for the various types of generalized and focal hyperhidrosis (**Figs. 2–7**). More information and practice aids are described in the article by Pieretti elsewhere in this issue, and can be found on the International Hyperhidrosis Society Web site (sweathelp.org).