

MEDICA®
UTILIZATION MANAGEMENT POLICY

TITLE: THORACIC SYMPATHECTOMY FOR PRIMARY HYPERHIDROSIS

EFFECTIVE DATE: August 20, 2018

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Please refer to the member's plan document for specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage.

With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless those programs require different coverage.

Medica may use tools developed by third parties, such as MCG Care Guidelines®, to assist in administering health benefits. Medica utilization management (UM) policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. Medica UM policies and MCG Care Guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica UM policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determines the medical necessity of thoracic sympathectomy for hyperhidrosis. The Benefit Considerations box below outlines the process for addressing the needs of individuals who do not meet these criteria.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, Medica uses MCG™ Care Guidelines, 21st edition, 2017: *ORG: S-1072 (ISC), Sympathectomy by Thoracoscopy or Laparoscopy.*

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for thoracic sympathectomy for primary hyperhidrosis. Please see the prior authorization list for product specific prior authorization requirements.
2. Coverage may vary according to the terms of the member's coverage document.
3. Cosmetic surgery is generally an exclusion in the member's plan document. If the above medical necessity criteria are not met, the procedure would be considered cosmetic.
4. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member's plan document.
5. If it appears that the Medical Necessity and Coverage Criteria are not met, the case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica Provider Administrative Manual.
6. See also related Medica drug coverage policy, *Botulinum Toxin (BTX) Treatment for Non-Cosmetic Indications*, for additional information regarding treatment for hyperhidrosis.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at: <http://www.cms.hhs.gov/mcd/search.asp?>

DOCUMENT HISTORY

Original Effective Date	June 2003
MPC Endorsement Date(s)	06/2004, 04/2005, 04/2006, 04/2007, 04/2008, 04/2009, 04/2010, 04/2011, 06/2012, 06/2013, 09/2014
Began use of MCG™ Care Guidelines	12/01/2015 (19 th edition)
MCG Care Guidelines Edition Updates (<i>Medica Effective Date</i>)	20 th edition: 10/10/2016, 21 st edition: 08/31/2017, 21 st edition reaffirmed: 08/20/2018
Administrative Updates	05/01/2017