Sentara Health Plans

Medicaid

Iontophoresis Treatment for Hyperhidrosis, DME 32

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Effective Date	1/1/2026
Next Review Date	09/2026
Coverage Policy	DME 32
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Iontophoresis uses an FDA approved device that produces electric stimulation to block sweat glands.

Criteria:

Iontophoresis treatment for hyperhidrosis is considered medically necessary with **ALL** of the following:

- The individual has experienced significant disruption of their professional and/or social life due to excessive sweating with indications of 1 or more of the following:
  - Trial of prescription strength antiperspirants unsuccessful
  - Presence of medical complications or skin maceration with secondary infection
  - Unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics, beta-blockers, benzodiazapines)
- FDA approved device only

Iontophoresis is considered **not medically necessary** for any use other than those indicated in clinical criteria.

Document History:

Revised Dates:

- 2019: November
- 2016: April

Reviewed Dates:

- 2025: September – Implementation date of January 1, 2026. Full annual review. No changes in criteria. New format.
- 2024: September – No changes to criteria, references.

- 2023: September
- 2022: September
- 2021: November
- 2020: October
- 2018: August
- 2017: November
- 2015: April
- 2014: April
- 2013: March
- 2012: March
- 2011: February
- 2010: February

Origination Date: January 2009

Coding:

Medically necessary with criteria:

Coding	Description
E1399	Durable medical equipment, miscellaneous.

Considered Not Medically Necessary:

Coding	Description
	None

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage:
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products:
  - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization requirements:
  - Pre-certification by the Plan is required.
- Special Notes:
  - Medicaid
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change

without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.
- Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

SHP Iontophoresis Treatment for Hyperhidrosis, SHP Durable Medical Equipment 32, excessive sweating, anticholinergics, beta-blockers, benzodiazapines, skin maceration, prescription strength antiperspirants, Fisher, Hidrex, Drionic, Dermadry