Sentara Health Plans

Medicaid

Iontophoresis Treatment for Hyperhidrosis, DME 32

Table of Content

Description & Definitions
Criteria
Document History
Coding
Special Notes
References
Keywords

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Coverage Policy	DME 32
Version	8

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:

- 2026: June – Implementation date of October 01, 2026. Annual review. No changes in criteria.
- 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:
  - 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 EPSDT Supplement B (updated 5.19.22)_Final.pdf
- **Documentation Requirements** DME Chapter IV (updated 5.23.25)_Final.pdf appendix-b-21-excel-version-with-all-categories-of-appendix-b-july-2025.xlsx
  - All durable medical equipment (DME) and supplies must be ordered by a practitioner on the form: CMN/DMAS-352 (revised 2017) and must be medically necessary to treat a health condition. The CMN/DMAS352 may be completed by the practitioner, DME provider, or other health care professionals, but the practitioner must sign and date the completed Certification of Medical Necessity (CMN).
  - The CMN and any supporting verifiable documentation must be completed (signed and dated by the practitioner) within 60 days.
  - The CMN shall be valid for a maximum period of six (6) months for Medicaid individuals under 21 years of age. The CMN shall be valid for a maximum period of twelve (12) months for Medicaid individuals 21 years and older.
- **Repair vs. Replacement Guidelines**
  - If individual owned equipment needs to be replaced prior to the service limit (Per Appendix B) expiring the provider will be required to justify and obtain service authorization.
  - Documentation for service authorization should include the required information as stated in this manual and the provider shall also include additional documentation as stated below:
    - What equipment the individual is currently using and why that equipment is no longer appropriate for the individual. This description shall include the reason why repairs could not be done or why the option to repair the equipment was not cost effective.
    - The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new equipment would be more cost effective; and
    - If the item is no longer appropriate due to a change in medical condition, limitations and symptoms, or if the equipment was provided inappropriately, the provider shall give justification to describe the circumstances.
- **Rental vs. Purchase Guideline**
  - When determined to be cost effective by SHP, payment may be made for rental of the equipment in lieu of purchase. (12 VAC 30-50-165)
  - When usage is anticipated to be long-term, and the individual's need or condition is not expected to change, the items must be considered for purchase

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).

(2026). Retrieved 4 2026, from Hayes: https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522iontophoresis%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522sources%2522:%25

29th Edition. (2026). Retrieved 4 2026, from MCG: https://careweb.careguidelines.com/ed29/

Iontophoresis. (2026). Retrieved 4 2026, from International Hyperhidrosis Society: https://www.sweathelp.org/treatments-hcp/iontophoresis.html#:~:text=Use%20nondeionized%20tap%20water%20(from,required%20on%20a%20frequent%20basis

NCD Durable Medical Equipment Reference List (280.1). (2025, 10). Retrieved 3 2026, from CMS: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=190&ncdver=4&keywordtype=starts&keyword=Durable&bc=0

Primary focal hyperhidrosis: Management. (2026, 3). Retrieved 4 2026, from UpToDate: https://www.uptodate.com/contents/primary-focal-hyperhidrosis-management?search=Iontophoresis&source=search_result&selectedTitle=1~25&usage_type=default&display_rank=1

Provider Manual Title: Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Appendix D: Service Authorization. (Revision Date: 9/12/2025). Retrieved 3 2026, from DMAS: https://vamedicaid.dmas.virginia.gov/sites/default/files/2025-10/DME%20Appendix%20D%20%28updated%209.12.25%29_Final.pdf

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