

Iontophoresis Treatment for Hyperhidrosis, DME 32

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Effective Date	1/1/2026
Next Review Date	09/2026
Coverage Policy	DME 32
Version	7

Member specific benefits take precedence over medical policy. Coverage varies across plans. Coverage varies across plans. Refer to the individual's benefit plan for coverage details*.

Description & Definitions:

Iontophoresis uses a 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 Medicare products.
- Authorization requirements: Pre-certification by the Plan is required.
- Special Notes:
 - Medicare:
 - This medical policy expresses Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. 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.

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).

(2025). Retrieved 6 2025, from MCG: <https://careweb.careguidelines.com/ed29/index.html>

(2025). Retrieved 7 2025, from CMS: <https://www.cms.gov/medicare-coverage-database/search-results.aspx?keyword=lontophoresis&keywordType=starts&areald=all&docType=NCA,CAL,NCD,MEDCAC,TA,MC,CD,6,3,5,1,F,P&contractOption=all>

Clinical Guidelines. (2025). Retrieved 7 2025, from The International Hyperhidrosis Society: https://www.sweathelp.org/index.php?option=com_content&view=article&id=93&Itemid=322

Hyperhidrosis. (2025). Retrieved 7 2025, from Hayes: <https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522Hyperhidrosis%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>

lontophoresis. (2023). Retrieved 7 2025, from MedlinePlus: <https://medlineplus.gov/ency/article/007293.htm>

Management of Primary Focal Hyperhidrosis: An Algorithmic Approach. (2021, 5). Retrieved 7 2025, from Journal of Drugs in Dermatology: <https://jddonline.com/articles/management-of-primary-focal-hyperhidrosis-an-algorithmic-approach-S1545961621P0523X/>

Primary focal hyperhidrosis. (2024, 5). Retrieved 7 2025, from UpToDate: https://www.uptodate.com/contents/primary-focal-hyperhidrosis?search=lontophoresis&source=search_result&selectedTitle=1~24&usage_type=default&display_rank=1

Provider Manual. (2025). Retrieved 7 2025, from DMAS: <https://www.dmas.virginia.gov/for-providers/>

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