Sentara® Health Plans

Commercial

Iontophoresis Treatment for Hyperhidrosis, DME 32

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Effective Date	10/1/2026
Next Review Date	06/2027
Coverage Policy	DME 32
Version	8

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for 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:

- 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. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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 Commercial products.
- Authorization requirements
  - Pre-certification by the Plan is required.
  - **Please refer to Prior Authorization List for most up to date requirement Search PAL List: Sentara Health Plans**
- Special Notes:
  - 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.
  - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

- **MUST SEE MEMBER BENEFIT FOR DETERMINATION.** We only cover DME that is Medically Necessary and prescribed by an appropriate Provider. We also cover colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters. We do not cover DME used primarily for the comfort and wellbeing of a Member. We will not cover DME if We deem it useful, but not absolutely necessary for Your care. We will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items.

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