I. Policy: Iontophoresis

II. Purpose/Objective:
To provide a policy of coverage regarding Iontophoresis

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**DESCRIPTION:**
Iontophoresis a method of transdermal local drug delivery using an electrical current. When drug and the iontophoresis setting have the same polarity, drug molecules are forced into the skin by electrostatic repulsion.

**INDICATIONS:**
Iontophoresis for the treatment of musculoskeletal inflammation resulting in pain and/or edema is considered to be medically necessary when used as part of an overall treatment protocol in any of the following conditions:

- Epicondylitis
- Patellofemoral syndrome
- Tendonitis (except Achilles tendonitis)
- Rotator cuff syndrome
- Plantar fasciitis
- Primary Focal hyperhidrosis if insured individual is unresponsive to topicals and pharmacologics (e.g. Topical chloride, anti-cholinergics, beta-blockers, benzodiazapines) (see MP258 Hyperhidrosis)

**EXCLUSIONS:**
The Plan does NOT provide coverage for iontophoresis as a “stand-alone” treatment for any indication because it is considered unproven. Although the currently available literature regarding the use of iontophoresis is encouraging, the studies have been conducted under varying conditions and protocols, making it impossible to establish superiority in effectiveness of this technology on health outcomes when compared to established technologies or treatments.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven services is outlined in MP 15 – Experimental, Investigational or Unproven Services or Treatment

**CODING ASSOCIATED WITH:** Iontophoresis

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.*

- **97033** Application of a modality to one or more areas; iontophoresis, each 15 minutes.

*Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL*

**LINE OF BUSINESS:**
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

**REFERENCES:**


TEC Assessment: Iontophoresis for Medical Indications. 2003; BlueCross and BlueShield Association Technology Evaluation Center, Vol 18, Tab 3


UpToDate. Primary focal hyperhidrosis. Last reviewed August 6, 2014. http://www.uptodate.com/contents/primary-focal-hyperhidrosis?source=machineLearning&search=iontophoresis&selectedTitle=1%7E17&sectionRank=2&anchor=H16#H1

This policy will be revised as necessary and reviewed no less than annually.

Devised: 03/27/08

Revised: 9/12 (added indications), 10/14 (added hyperhidrosis as indication)

Reviewed: 9/11, 10/13, 10/15, 10/16