Policy Number	**RAD601.014**
Policy Effective Date	**11/01/2025**

Thermography

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Related Policies (if applicable)
None

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

Thermography for any indication (including breast lesions) **is considered experimental, investigational and/or unproven.**

Policy Guidelines

None.

Description

Thermography is a noninvasive imaging technique that measures temperature distribution in organs and tissues. The visual display of this temperature information is known as a thermogram. Thermography has been proposed as a diagnostic tool for treatment planning, and for evaluation of treatment effects for a variety of conditions.

Background

Infrared radiation from the skin or organ tissue reveals temperature variations by producing brightly colored patterns on a liquid crystal display. Thermography involves the use of an infrared scanning device and can include various types of telethermographic infrared detector images and heat-sensitive cholesteric liquid crystal systems.

Interpretation of the color patterns is thought to assist in the diagnosis of many disorders such as complex regional pain syndrome (previously known as reflex sympathetic dystrophy), breast cancer, Raynaud phenomenon, digital artery vasospasm in hand-arm vibration syndrome, peripheral nerve damage following trauma, impaired spermatogenesis in infertile men, degree of burns, deep vein thrombosis, gastric cancer, tear-film layer stability in dry-eye syndrome, Frey syndrome, headaches, lower back pain, and vertebral subluxation.

Thermography may also assist in treatment planning and procedure guidance by accomplishing the following tasks: identifying restricted areas of perfusion in coronary artery bypass grafting, identifying unstable atherosclerotic plaques, assessing response to methylprednisone in rheumatoid arthritis, and locating high undescended testicles.

Regulatory Status

A number of thermographic devices have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. FDA product codes: LHQ, FXN. Devices with product code LHQ may only be marketed for adjunct use. Devices with product code FXN do not provide a diagnosis or therapy. Examples of these devices are shown in Table 1.

Table 1. Thermography Devices Cleared by the U.S. Food and Drug Administration

Device Name	Manufacturer	Clearance Date	510(K) No.
Infrared Sciences Breastscan IR System	Infrared Sciences	Feb 2004	K032350
Telethermographic Camera, Series A, E, S, and P	FLIR Systems	Mar 2004	K033967
Notouch Breastscan	UE Lifesciences	Feb 2012	K113259
WoundVision Scout™	WoundVision	Dec 2013	K131596
AlfaSight 9000 Thermographic System™	Alfa Thermodiagnostics	Apr 2015	K150457
FirstSense Breast Exam®	First Sense Medical	Jun 2016	K160573
Sentinel BreastScan II System	First Sense Medical	Jan 2017	K162767
InTouch Thermal Camera	InTouch Technologies	Feb 2019	K181716
Smile-100 System	Niramai Health Analytix Private Limited	Mar 2022	K212965
ThermPix™ Thermovisual Camera	USA Therm	Apr 2022	K213650

Rationale

This policy is based on a review of coverage guidance from the Centers for Medicare and Medicaid Services (CMS) specific to thermography.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	93740, 93799
HCPCS Codes	None

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

References

National Coverage Determination:

1. Centers for Medicare and Medicaid Services. National Coverage Determination for Thermography (220.11) (December 21, 1992). Available at <https://www.cms.gov> (accessed September 10, 2025).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
11/01/2025	Document updated. Coverage revised without change to intent. Added reference 1; others removed.
04/01/2025	Document updated with literature review. Coverage unchanged. Added/updated the following references: 44, 46-48.

11/15/2024	Reviewed. No changes.
12/01/2023	Document updated with literature review. Coverage unchanged. Added/updated the following references: 31, 34-35, 46, and 49-52.
10/01/2022	Document updated with literature review. Coverage unchanged. Added/updated the following references: 15, 19, and 43.
02/01/2022	Reviewed. No changes.
07/15/2021	Document updated with literature review. Coverage unchanged. Added/updated the following references: 29, 35, 37, and 41.
01/15/2021	Reviewed. No changes.
08/15/2020	Document updated with literature review. Coverage unchanged. References 3, 4, 8, 9, 18, 24-28, 33, 36, 37 and 40 added, others updated.
04/01/2019	Document updated with literature review. Coverage unchanged. The following references were added: 3, 9, 15-20, 22-24.
04/15/2018	Reviewed. No changes.
03/01/2017	Document updated with literature review. Coverage unchanged.
02/15/2016	Reviewed. No changes.
02/01/2015	Document updated with literature review. Coverage unchanged.
09/01/2011	Document reviewed with literature review. Coverage unchanged, rationale and description updated.
02/15/2008	Revised/updated entire document
01/01/2006	Revised/updated entire document
10/24/2006	Revised/updated entire document
03/01/2005	CPT/HCPCS code(s) updated, medical policy unchanged
10/24/2003	Revised/updated entire document
11/01/1997	Revised/updated entire document
05/01/1996	Revised/updated entire document