Eviti Imaging: Colorectal Cancer

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Please note the following:

For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Please refer to the CMS website at http://www.cms.gov for additional information.

For Medicaid members/enrollees, circumstances when state Medicaid coverage provisions conflict with the coverage provisions within this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Colorectal Cancer Imaging

Discussion

This imaging guideline provides a standardized framework for the use of diagnostic and surveillance imaging in the management of common adult malignancies, specifically colorectal cancer. The goal is to ensure timely, evidence-based imaging that supports accurate staging, treatment planning, response assessment, and post-treatment surveillance.

Guiding Principles

- Follow evidence-based practices from major guidelines (e.g., NCCN, ESMO, ACR Appropriateness Criteria)
- Ensure imaging aligns with the clinical context and stage of disease
- Minimization of unnecessary radiation exposure
- Promote timely and cost-effective imaging utilization
- Incorporate multidisciplinary collaboration in imaging decisions

Imaging Guidelines

This guideline applies to the following patients:

1. At least 18 years of age with confirmed or suspected diagnoses of colorectal cancer; AND
2. All phases of oncologic care, including one of the following:
   a) Initial staging
   b) Treatment response evaluation
   c) Post-treatment surveillance
   d) Detection of recurrence or progression; AND
3. All imaging modalities used in oncology care, including but not limited to the following:
   a) Computed tomography (CT) (neck, chest, abdomen, pelvis, neck, or site-specific)
   b) Magnetic resonance imaging (MRI) (including site-specific protocols such as pelvis MRI, brain MRI, liver MRI)
   c) Fluorodeoxyglucose positron emission tomography/CT (FDG-PET/CT)
   d) PET/MRI
   e) Somatostatin receptor PET/CT (SSTR-PET/CT)
   f) Nuclear medicine (e.g., bone scan, PSMA PET)
   g) Single photon emission computed tomography/CT (SPECT/CT) (e.g., octreotide SPECT/CT for neuroendocrine tumors)

Notes:

1. The concurrent utilization of multiple advanced imaging modalities—such as PET/CT and MRI—is not routinely warranted and should be considered only when each modality is expected to provide distinct and clinically relevant information that will directly impact patient management. The selection of the most appropriate imaging study should be individualized, taking into account tumor type, clinical presentation, prior imaging, and other patient-specific factors. Imaging requests will be evaluated on a case-by-case basis to ensure clinical necessity, appropriateness, and the potential to influence therapeutic decision-making.

2. When PET imaging is clinically indicated, the appropriate radiotracer should be selected based on tumor type and clinical scenario.

Colorectal Cancer Imaging

Imaging in colorectal cancer is essential for accurate staging, operative planning, and post-treatment surveillance. CT chest/abdomen/pelvis is the mainstay for defining locoregional and distant disease, while MRI of the pelvis is indispensable for rectal cancer staging, enabling precise assessment of the circumferential resection margin and nodal status.
MRI of the liver or contrast-enhanced CT aids in defining hepatic metastases, particularly when resection or ablation is being considered. PET/CT is reserved for equivocal cases or when findings may alter management, such as assessing resect ability of metastatic disease. Appropriate imaging intervals reduce radiation exposure and support timely therapeutic decision-making consistent with NCCN guidance.

Rectal cancer requires more detailed local imaging than colon cancer, with MRI of the pelvis being the cornerstone for staging. Imaging defines tumor extent, circumferential resection margin, and nodal status, and it informs neoadjuvant treatment planning.

Colorectal Cancer Recommendations			
Clinical Scenario	**Recommended Modality**	**Frequency/Timing**	**Purpose/Notes**
Initial Diagnosis & Staging	CT chest/abdomen/pelvis	At diagnosis	Evaluate primary tumor, lymph nodes, liver, lung metastases
	MRI abdomen/pelvis	As indicated (for colon cancer) MRI pelvis is required for rectal cancer	May be useful in differentiating low-lying sigmoid versus rectal cancer
	MRI liver (if indeterminate liver lesions)	As indicated	Clarify extent of hepatic metastases, especially if liver directed therapy planned
	PET/CT	Only if conventional imaging is inconclusive or for metastatic disease evaluation	Not routine for initial staging
Treatment Response Monitoring	CT abdomen/pelvis	Prior to planned surgery, before adjuvant therapy, or re-evaluation of conversion to	Assess local extent and resectability

		resectable disease after neoadjuvant therapy	
	MRI pelvis	Prior to planned surgery for rectal cancer	
	PET/CT	Once for assessment of response to liver directed therapy	Not routinely indicated
	MRI liver	Once for assessment of response to liver directed therapy	Not routinely indicated
Post-Surgical Surveillance (Stages II–III)	CT chest/abdomen/pelvis	Every 6–12 months for 5 years	Detect recurrence/metastases
	MRI pelvis	Every 3-6 months for 2 years, then every 6 months for 3 years in patients with rectal cancer	For patients with transanal local excision cancer only
	CEA-guided imaging	As clinically indicated; typically, 3-6 months	Rising CEA prompts earlier scans
Post-Surgical Surveillance (Stage IV)	CT chest/abdomen/pelvis	Every 3-6 months for 2 years, then every 6-12 months for 3 years	
	MRI pelvis	Every 3-6 months for 2 years, then every 6 months for 3 years in patients with rectal cancer	
	CEA-guided imaging	As clinically indicated; typically, 3-6 months	
Metastatic Disease Monitoring	CT chest/abdomen/pelvis ± MRI liver	Every 2–3 months on active therapy	Assess treatment response, resectability of metastases
Suspected Recurrence	CT chest/abdomen/pelvis	As indicated	Evaluate symptoms, abnormal CEA, or clinical suspicion
	PET/CT	Once only if conventional imaging is inconclusive or for metastatic disease evaluation to determine resectability	May be helpful when CEA rising and conventional imaging if non-diagnostic

Notes:

1. MRI pelvis is required for rectal staging and restaging.
2. PET/CT reserved for inconclusive or metastatic settings.
3. CEA trends guide timing of imaging.
4. Avoid PET for routine surveillance unless justified by abnormal CEA and nondiagnostic CT.[1]

Revision and Review History

No.	Description	Date
1	Original Effective Date:	1/1/2026
2	Policy Annual Review Dates:	
3	Department Owner:	Medical Affairs
4	NH Advisory Committee Approval Dates:	
5	Revision Changes:	

References

[1] National Comprehensive Cancer Network Guidelines: Colon Cancer https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed December 15, 2025.