

Eviti Imaging: Cutaneous Melanoma

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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.

Cutaneous Melanoma 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 cutaneous melanoma. 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 cutaneous melanoma;
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.

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

Cutaneous Melanoma Imaging

Imaging in cutaneous melanoma provides critical information for staging, treatment planning, and recurrence detection. Early-stage (I–II) melanoma generally does not require cross-sectional imaging unless symptomatic or clinically suspicious. For stage IIB–IV disease, CT chest/abdomen/pelvis or FDG-PET/CT identifies nodal, visceral, and subcutaneous metastases. Brain MRI is the preferred modality for detecting CNS involvement, particularly in stage III–IV or neurologically symptomatic patients.

Surveillance imaging frequency should reflect disease stage, treatment status, and relapse risk, avoiding low-value routine PET scans beyond five years of disease-free follow-up.

Cutaneous Melanoma Recommendations			
Clinical Scenario	Recommended Modality	Frequency/Timing	Purpose/Notes
Primary Localized Melanoma (Clinical Stage 0, I–II, Asymptomatic)	No routine cross-sectional imaging	N/A	History/physical ± dermatologic follow-up; imaging only if symptoms or abnormal exam/labs
Sentinel Node Planning	Lymphoscintigraphy (± SPECT/CT per local practice)	Pre-op, day of/preceding sentinel node biopsy	Map draining basin(s) for sentinel node biopsy; Breslow ≥1.0 mm (T2–T4), any ulceration status OR Stage IB–II disease overall (i.e., stage T1b–T4), if no palpable/clinically involved nodes; considered stage T1a if additional high-risk factors
Staging for High-Risk Localized (e.g., Stage IIB–IIC Based on Pathology) or Any Stage III/IV	CT chest/abdomen/Pelvis or FDG-PET/CT	At diagnosis/baseline	Detect nodal/visceral disease; PET/CT helpful for whole-body overview; imaging for stage IIB/IIC being considered for adjuvant therapy
CNS Staging (Stage III–IV or Neuro Symptoms)	Brain MRI	At diagnosis/baseline	Screen for brain metastases (common sanctuary site)

Treatment Response (Neoadjuvant Therapy)	CT chest/abdomen/pelvis or FDG-PET/CT	Every 6-12 weeks	Assess for residual disease/metastatic disease and surgical resection
Treatment Response (Systemic Therapy, Stage III–IV)	CT chest/abdomen/pelvis or FDG-PET/CT	Every 2-6 months during active therapy, then per regimen	Assess response/progression; align with RECIST/immune-related criteria; stage III local satellite/in-transit disease, unresectable or incompletely resected nodal disease
Post-Treatment Surveillance (Resected Stage IIB–IV NED)	CT chest/abdomen/pelvis ± neck	Every 3–12 months for 2 years, then every 6-12 months for 3 years As indicated	Earlier if symptoms or exam findings
	MRI brain	As clinically indicated	Asymptomatic screening is appropriate for stage IIIB or greater
Suspected Recurrence/Progression	CT or PET/CT ± Brain MRI	As clinically indicated	Based on symptoms, exam, or rising LDH

Notes:

1. Avoid routine baseline imaging in low-risk stage I–II without symptoms.
2. PET/CT and CT are generally interchangeable for systemic staging; PET/CT may better detect occult disease in stage III–IV.
3. Brain MRI is preferred over CT for CNS assessment. MRI brain required for stage III–IV or neurologic symptoms.
4. Use imaging cadence that aligns with the treatment cycle and clinical risk; do not combine multiple advanced modalities unless each will change management.
5. After 3–5 years of disease-free follow-up, routine imaging is generally not recommended unless clinically indicated.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: Melanoma: Cutaneous.
https://www.nccn.org/professionals/physician_gls/pdf/cutaneous_melanoma.pdf. Accessed December 15, 2025.