IMAGING GUIDELINES FOR MEDICAL NECESSITY

Eviti Imaging: Esophageal 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.

Esophageal 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 esophageal 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 esophageal 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.

Esophageal Cancer Imaging

Imaging in esophageal cancer is essential for accurate diagnosis, staging, treatment planning, and detection of recurrence. The goals are to define the local extent of the primary tumor, assess nodal involvement, and identify distant metastases. NCCN emphasizes a multimodality approach using endoscopy, endoscopic ultrasound, and cross-sectional imaging to determine resectability and guide therapeutic strategy. Following definitive therapy, surveillance imaging helps detect recurrence early and monitor treatment-related effects.
These recommendations apply to esophageal squamous cell carcinoma and adenocarcinoma, including gastroesophageal junction (GEJ) tumors.

Esophageal Cancer Recommendations			
Clinical Scenario	**Recommended Modality**	**Frequency/Timing**	**Purpose/Notes**
Initial Diagnosis/ Staging	CT chest, abdomen, pelvis	Once at diagnosis	Evaluate primary tumor, regional nodes, and distant metastases (liver, lungs, adrenals)
	Endoscopic ultrasound (EUS)	Once, when feasible	Defines local T and N stage; particularly important for potentially resectable disease
	PET/CT (FDG), when clinically indicated due to inconclusive or inadequate findings on conventional imaging	Once at staging	Recommended to evaluate for occult distant metastases; per NCCN, especially for locally advanced disease
Treatment Monitoring (Curative)	PET/CT CT chest/abdomen/pelvis	5-8 weeks after completion of pre-op therapy and within 3–6 months post-surgery	Restage to assess response and continued resectability (May omit if PET done)
Treatment Monitoring (Metastatic)	CT chest/abdomen/pelvis	Every 3 months	NCCN does not specify imaging intervals

	PET/CT, when clinically indicated due to inconclusive or inadequate findings on conventional imaging		
Surveillance (Post-Curative Therapy) for Stage T1b and Above	CT chest/abdomen/pelvis	Every 6 months for first 2 years, then annually up to 5 years (post-surgery); Every 3-6 months for first 2 years, then annually up to 5 years (post-CRT alone)	Frequency individualized by stage, histology, and recurrence risk
Suspected Recurrence/ Progression	CT chest/abdomen/pelvis	As indicated	Evaluate for local recurrence, regional nodes, or distant spread
	PET/CT, when clinically indicated due to inconclusive or inadequate findings on conventional imaging		Clarify equivocal CT findings or when recurrence suspected but not confirmed
	MRI (liver protocol)		Characterize indeterminate hepatic lesions

Notes:

1. PET/CT is strongly recommended for initial staging and selective use in restaging; not for routine surveillance.
2. EUS may be limited in highly obstructing lesions; alternate imaging should be used for nodal assessment.
3. Avoid duplication of modalities unless clinically justified.
4. For surveillance, CT scans are preferred. For patients who cannot undergo CT scan, alternative imaging such as PET/CT or MRI may be completed as clinically indicated.
5. MRI or ultrasound may be substituted in patients unable to receive IV contrast.
6. Surveillance intensity should reflect treatment intent and recurrence risk (e.g., definitive chemoradiation vs surgical resection).[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: Esophageal Cancer. https://www.nccn.org/professionals/physician_gls/pdf/esophageal.pdf. Accessed December 16, 2025.