**IMAGING GUIDELINES FOR MEDICAL NECESSITY**

# Eviti Imaging: General Oncologic

**Version: 1.0**

**Effective Date: 1/1/2026**

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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.

# General Oncologic Imaging

## Discussion

This imaging guideline provides a standardized framework for the use of diagnostic and surveillance imaging in the management of common adult malignancies, general oncologic. 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 general oncologic 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.

## General Oncologic Imaging

Imaging serves as the backbone of oncologic evaluation across all malignancies, guiding diagnosis, initial staging, response assessment, and long-term surveillance. When tumor-specific imaging protocols are not yet defined, cross-sectional imaging—particularly CT of the chest, abdomen, and pelvis—remains the standard reference framework.

MRI and PET/CT provide complementary physiological and metabolic data when conventional imaging is inconclusive, contraindicated, or requires soft-tissue differentiation.
Utilization of advanced imaging should balance diagnostic value, radiation exposure, and cost, while ensuring alignment with NCCN Category 1/2A recommendations and ACR medical necessity standards.

This general oncologic imaging guideline applies to all cancer types in the absence of an approved tumor-specific policy.

| General Oncologic Recommendations | | | |
|---|---|---|---|
| **Clinical Scenario** | **Recommended Modality** | **Frequency/Timing** | **Purpose/Notes** |
| **Initial Diagnosis/ Staging** | CT chest/abdomen/pelvis | Once at diagnosis or initial staging | Baseline imaging modality for most solid tumors |
| | CT neck | | If head/neck primary or cervical lymphadenopathy suspected |
| | MRI | | If CT is contraindicated, limited by contrast allergy, or when superior soft-tissue delineation is required (e.g., CNS, liver, pelvis, musculoskeletal, or spine) |

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|---|---|---|---|
| | FDG-PET/CT | | Disease is FDG-avid and conventional imaging is inconclusive or discordant with clinical findings. PET is required for accurate staging (e.g., suspected occult metastasis or systemic involvement)<br><br>Establish baseline extent of disease, nodal/extra nodal involvement, and guide treatment planning. PET or MRI reserved for cases where anatomic imaging is insufficient or guideline supported |
| **Treatment Monitoring/ Response Assessment Stage IV** | CT chest/abdomen/pelvis<br><br>MRI may substitute if target lesion is better visualized by MRI or when CT contraindicated<br><br>PET/CT (may be approved for FDG-avid tumors when metabolic response is required to confirm complete or partial remission, or when CT is equivocal) | At clinically appropriate intervals per regimen (typically every 2–3 cycles for cytotoxic therapy or 8–12 weeks for targeted/immunotherapy)<br><br>Otherwise, every 3 months during active therapy | Assess interval change in tumor burden, confirm radiographic or metabolic response, identify progression or pseudo progression. Frequency should align with NCCN disease-specific guidance |
| **Surveillance Stages I-III** | CT chest/abdomen/pelvis | At defined intervals depending on risk of recurrence and disease type (commonly every 3–6 months for the first 2 years, then annually up | Detect recurrence, new metastases, or treatment-related complications. Routine PET/CT |

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|---|---|---|---|
| | MRI or PET/CT | to 5 years if clinically warranted)<br><br>Refer to NCCN for tumor specific recommendations | for surveillance discouraged unless NCCN Category 1/2A supports its use<br><br>Reserved for cases with inconclusive CT findings or when clinically indicated by symptoms, labs, or elevated tumor markers |
| **New or Worsening Symptoms/ Suspected Relapse** | CT chest/abdomen/pelvis (targeted region if appropriate)<br><br>±<br><br>MRI<br>or<br>PET/CT | As clinically indicated one time<br><br>If indicated | Evaluate suspected recurrence, new pain, neurologic deficits, or lab progression not explained by prior imaging |

**Notes:**

1. Aligns with NCCN v.2025 (Category 1/2A) principles when tumor-specific guidance is absent.
2. Baseline CT Chest/Abdomen/Pelvis with contrast remains standard for most solid tumors.
3. MRI is preferred when CT is nondiagnostic or contraindicated, or when superior soft-tissue detail is needed.
4. FDG-PET/CT approved when findings are inconclusive or discordant.
5. Routine PET/CT surveillance discouraged unless NCCN explicitly supports.
6. UM decisions defer to NCCN Category 1/2A evidence; Category 2B or lower requires MD review.[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. https://www.nccn.org/guidelines/category_1. Accessed December 16, 2025.