

# Eviti Imaging: Head and Neck Cancer

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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.

## Head and Neck 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 head and neck 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 head and neck 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.

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

### **Head and Neck Cancer Imaging**

Imaging plays a central role in the diagnosis, staging, treatment planning, and post-therapy surveillance of head and neck cancers (HNC). The overarching objectives are to define the local and regional extent of disease, assess nodal involvement, evaluate for perineural or skull-base invasion, and identify distant metastases.

The NCCN Guidelines recommend a multimodality approach using contrast-enhanced CT, MRI, and FDG PET/CT, tailored to the primary site, stage, and clinical presentation. Imaging findings inform decisions regarding resectability, radiation field design, and systemic therapy planning. This guideline applies to squamous cell carcinoma of the upper aerodigestive tract (oral cavity, oropharynx, hypopharynx, larynx) and includes site-specific adaptations for nasopharyngeal, sinonasal, salivary, and thyroid malignancies.

<b>Head and Neck Cancer Recommendations</b>			
<b>Clinical Scenario</b>	<b>Recommended Modality</b>	<b>Frequency/Timing</b>	<b>Purpose/Notes</b>
<b>Initial Staging</b>	CT neck ± CT chest	Once at diagnosis	Defines primary tumor extent, nodal disease, and thoracic metastases
	MRI neck ± skull base, when clinically indicated	Once at diagnosis	MRI is preferred over CT for bone marrow invasion, patients with extensive dental amalgam, to assess skull base invasion, cranial nerve involvement, intracranial/orbital invasion, to differentiate tumor from obstructed sinuses and for perineural spread
	FDG-PET/CT, when clinically indicated due to inconclusive or inadequate findings on conventional imaging	Once at staging	Detects occult primary or distant metastases; recommended for stage III–IV disease

<b>Treatment Monitoring</b>	FDG-PET/CT	Post-chemoradiation At least 12 weeks after completion (may repeat in 3-6 months if results equivocal)	Standard for post-treatment assessment; avoid imaging <10 weeks to reduce false positives
	CT/MRI neck +/- chest/abdomen/pelvis	Post surgery within 3-4 months  Induction therapy every 2-3 cycles to assess response  Locally advanced or metastatic disease Every 3 months for monitoring disease response as clinically indicated	NCCN does not specify imaging interval
<b>Surveillance</b>	CT or MRI neck ± FDG-PET/CT, as indicated	Annually for 5 years	Detect local/regional recurrence or second primary tumors. NCCN does not specify imaging interval
<b>Suspected Recurrence</b>	FDG-PET/CT, when clinically indicated due to inconclusive findings	As clinically indicated	Identify recurrence or distant metastases
	MRI brain ± skull base	As clinically indicated	Evaluate suspected perineural or intracranial spread
<b>Subsections – Site-Specific Considerations</b>			
<b>Nasopharyngeal Carcinoma</b>	<p>MRI head and neck with contrast is mandatory for local staging, skull-base invasion, and perineural spread</p> <p>PET/CT recommended at diagnosis and 10–12 weeks post-therapy to evaluate nodal and distant metastases</p> <p>Brain MRI considered for neurologic symptoms or cranial nerve involvement</p>		

<p><b>Sinonasal Malignancies</b></p>	<p>MRI is preferred for assessing intracranial extension, orbital invasion, and perineural spread.</p> <p>CT of paranasal sinuses and skull base defines osseous erosion or remodeling</p> <p>PET/CT may assist in staging and post-treatment assessment, especially for high-grade histologies</p>
<p><b>Salivary Gland Malignancies</b></p>	<p>MRI neck is first line for local extent and perineural tracking along cranial nerves V and VII</p> <p>CT neck/chest to evaluate nodal and pulmonary metastases</p>

**Notes:**

1. PET/CT is preferred for treatment response evaluation approximately 12 weeks post-chemoradiation; earlier imaging may yield false positives.
2. MRI is superior for soft-tissue detail, perineural spread, and skull base assessment, while CT is preferred for bone invasion.
3. PET/CT is not routinely indicated for low-stage (I–II) disease unless findings are equivocal.
4. Avoid duplication of imaging modalities unless clinically justified or when findings are discordant.
5. Surveillance frequency should be individualized based on tumor site, stage, and recurrence risk.
6. Chest imaging (CT or PET/CT) should be included at baseline and follow-up due to risk of pulmonary metastases or synchronous primaries.<sup>1</sup>

**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**

<sup>1</sup> National Comprehensive Cancer Network Guidelines: Head and Neck Cancer. [https://www.nccn.org/professionals/physician\\_gls/pdf/head-and-neck.pdf](https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf). Accessed December 16, 2025.