

Eviti Imaging: Kidney Cancer

Version: 1.0

Effective Date: 1/1/2026



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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.

Kidney 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 kidney 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 kidney 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.

Kidney Cancer Imaging

Imaging in kidney cancer is fundamental for initial diagnosis, surgical planning, and post-treatment monitoring. Multiphase CT abdomen/pelvis or renal-mass-protocol MRI offers optimal assessment of lesion enhancement, venous invasion, and local extension. CT chest complements staging by evaluating pulmonary metastases.

MRI is preferred in patients with contrast allergy, renal insufficiency, or suspected IVC thrombus. FDG-PET/CT has limited routine use but may assist in atypical histologies or indeterminate lesions.

Surveillance frequency should be individualized by stage, histologic grade, and margin status in alignment with NCCN Guidelines.

Kidney Cancer Recommendations			
Clinical Scenario	Recommended Modality	Frequency/Timing	Purpose/Notes
Initial Staging	CT chest CT abdomen/pelvis or MRI abdomen/pelvis	Once at diagnosis	Characterize mass, enhancement, fat, complexity; assess renal vein/IVC, perinephric invasion
	MRI brain, bone scan	As clinically indicated for symptoms or abnormal labs (e.g., bone pain, ↑ALP, neuro symptoms)	Not routine for asymptomatic localized disease
	FDG-PET	As clinically indicated	Not routinely recommended except in select circumstances (e.g., bone-predominant disease, FH- or SDHB-deficient RCC, assessment prior to mastectomy)
Treatment Monitoring - Metastatic Disease on Systemic Therapy	CT chest/ abdomen/pelvis	Every 6–16 weeks initially, then per regimen	Monitor response and toxicities, tailor interval to therapy and kinetics
	MRI liver	As clinically indicated	Not routinely recommended

	FDG-PET	As clinically indicated	except in select circumstances (e.g., bone-predominant disease, FH- or SDHB-deficient RCC, assessment prior to mastectomy) except in select circumstances (e.g., bone-predominant disease, FH- or SDHB-deficient RCC, assessment prior to mastectomy)
Surveillance - Active Surveillance	CT or MRI abdomen	Within 6 months of starting surveillance, then every 12 months at baseline and then every 12 months	
	CT chest	Every 12 months	
Surveillance - Post-Ablation	CT or MRI abdomen	At 1-3 months, 6 months, and 12 months after ablation; annually thereafter	Detect local recurrence/new lesions
	CT chest	Annually	
Surveillance - Post SBRT	CT abdomen/chest	Every 3 months for 1 year, every 6 months for year 2, every 9 months for year 3-4, then annually at year 5	Detect local recurrence/new lesions
Surveillance - Post-Op Stage I	CT/MRI abdomen	Within 3-12 months of surgery then every 12 months	High risk features (e.g. positive margins and adverse pathologic features may necessitate more rigorous surveillance)
	CT chest	Every 12 months	

Surveillance - Post-Op Stage II	CT or MRI abdomen/pelvis	Every 6 months for 2 years then annually for up to 5 years	High risk features (e.g. positive margins and adverse pathologic features may necessitate more rigorous surveillance)
	CT chest	Every 12 months	
Surveillance - Post-Op Stage III	CT or MRI abdomen/pelvis	Every 3-6 months for 3 years, then annually up to 5 years	Higher recurrence risk warrants closer imaging
Suspected Recurrence	CT/MRI abdomen/pelvis ± CT chest	As clinically indicated	Symptom or lab-driven evaluation
	FDG-PET	As clinically indicated	Not routinely recommended except in select circumstances (e.g., bone-predominant disease, FH- or SDHB-deficient RCC, assessment prior to mastectomy)

Notes:

1. MRI preferred if iodinated contrast is contraindicated, to evaluate renal vein/IVC thrombus, or to characterize indeterminate lesions.
2. FDG-PET/CT is not routinely recommended in RCC (variable avidity); consider selectively for problem-solving or atypical histology's.
3. Tailor surveillance intensity to pathologic stage, grade, and margin status; avoid duplicative imaging when prior studies adequately answer the question.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: Kidney Cancer. https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed December 16, 2025.