IMAGING GUIDELINES FOR MEDICAL NECESSITY

Eviti Imaging: Uterine 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.

Uterine 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 uterine 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 uterine 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.

Uterine Cancer Imaging

Imaging in uterine malignancies assists in preoperative staging, surgical planning, and post-treatment assessment. MRI of the pelvis is the modality of choice for evaluating depth of myometrial invasion, cervical stromal involvement, and parametrial spread. CT chest/abdomen/pelvis helps detect advanced disease, especially in high-grade histology's or stage III/IV cases.

PET/CT adds value when conventional imaging is inconclusive or recurrence is suspected, particularly in high-risk subtypes such as serous or carcinosarcoma.
Routine imaging is not warranted for asymptomatic early-stage patients; follow-up is largely clinical per NCCN Category 1/2A recommendations.

Uterine Cancer Recommendations			
Clinical Scenario	**Recommended Modality**	**Frequency/Timing**	**Purpose/Notes**
Initial Diagnosis	Chest imaging	At diagnosis	CT chest to follow if abnormality seen on chest x-ray
	Pelvic MRI	At diagnosis	Best for assessing depth of myometrial invasion, cervical stromal involvement, and parametrial extension if needed; especially useful if fertility sparing surgery planned
	Transvaginal ultrasound	At diagnosis	Often first-line to identify endometrial thickening or mass; guides biopsy
	CT chest/abdomen/pelvis	At diagnosis	Generally reserved for patients with advanced stage (III/IV), high-risk histology (serous, clear cell, undifferentiated carcinoma, or carcinosarcoma), and high-grade tumors

	PET/CT; when clinically indicated due to inconclusive or inadequate findings on conventional imaging	As indicated	May improve detection of nodal or distant metastases; not routinely indicated for low risk endometrioid histology
Treatment Monitoring for Locally Advanced or Metastatic Disease	CT chest/abdomen/pelvis	Every 3 months	To evaluate treatment response to ongoing therapy
Persistent Endometrial Cancer After Fertility Sparing Treatment	MRI pelvis	After 6-9 months of ineffective treatment	
Surveillance (Endometrial Carcinoma)	None routinely required	N/A	Routine imaging not indicated in asymptomatic patients; follow-up is clinical
Surveillance (Uterine Sarcoma)	CT chest/abdomen/pelvis +/- MRI abdomen and pelvis PET/CT, when clinically indicated due to inconclusive or inadequate findings on conventional imaging	Every 3-6 months for 3 years, then 6-12 months for up to 5 years; imaging annually or every other year for an additional 5 years based on histology, grade, and initial stage As indicated	Detect recurrence in high-risk histology or advanced stage
Suspected Recurrence	CT chest/abdomen/pelvis ± MRI abdomen/pelvis +/- PET/CT, as clinically indicated when conventional imaging	As clinically indicated	Evaluate symptoms, abnormal exam findings, or rising tumor markers

	provides insufficient information		

Notes:

1. MRI is superior to CT for evaluating local extent and myometrial invasion.
2. PET/CT is most valuable for restaging or detecting recurrence, especially in high-grade or non-endometrioid subtypes.
3. Routine imaging surveillance is not recommended for asymptomatic patients with low-risk early-stage disease; imaging should be guided by symptoms or exam findings.[1]

Revision and Review History

No.	Description	Date
1	Original Effective Date:	
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: Uterine Neoplasms. https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed December 15, 2025.