CIGNA MEDICAL COVERAGE POLICIES– RADIOLOGY

Oncology Imaging Guidelines

Effective Date: February 02, 2027

Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer's benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by EviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

These guidelines include procedures EviCore does not review for Cigna. Please refer to the **Cigna CPT code list** for the current list of high-tech imaging procedures that EviCore reviews for Cigna.

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These guidelines apply to services or supplies managed by EviCore for Cigna as outlined by the Cigna CPT list.

General Criteria (ONC-1)

Guideline Page

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Oncology Imaging Guidelines

Abbreviations for Oncology Imaging Guidelines

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Abbreviations for Oncology Imaging Guidelines	
ACTH	adrenocorticotropic hormone
AFP	alpha-fetoprotein
ALKP	alkaline phosphatase
AP	anteroposterior
betaHCG	beta human chorionic gonadotropin
CA 125	cancer antigen 125 test
CA 19-9	cancer antigen 19-9
CA 15-3	cancer antigen 15-3
CA 27-29	cancer antigen 27-29
CBC	complete blood count
CEA	carcinoembryonic antigen
CNS	central nervous system
CR	complete response
CTA	computed tomography angiography
DCIS	ductal carcinoma in situ
DLBCL	diffuse large B cell lymphomas
DRE	digital rectal exam
EGD	esophagogastroduodenoscopy
ENT	ear, nose, throat
EOT	end of therapy
ERCP	endoscopic retrograde cholangiopancreatography
ESR	erythrocyte sedimentation rate
EUA	exam under anesthesia

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Abbreviations for Oncology Imaging Guidelines	
EUS	endoscopic ultrasound
FDG	fluorodeoxyglucose
FNA	fine needle aspiration
FUO	fever of unknown origin
GE	gastroesophageal
GI	gastrointestinal
GU	genitourinary
GTR	gross total resection
HG	high-grade
HIV	human immunodeficiency disease
HRPC	hormone refractory prostate cancer
hypermet	hypermetabolic
IFRT	involved field radiation therapy
inv	invasive
LAR	low anterior resection
LCIS	lobular carcinoma in situ
LDH	lactate dehydrogenase
LFT	liver function tests
LND	lymph node dissection
LVI	lymphovascular invasion
MALT	mucosa associated lymphoid tissue
maint	maintenance
MEN	multiple endocrine neoplasia
MG	myasthenia gravis
MGUS	monoclonal gammopathy of unknown significance
MIBG	I-123 metaiodobenzylguanidine scintigraphy
MRA	magnetic resonance angiography

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Abbreviations for Oncology Imaging Guidelines	
MRCP	magnetic resonance cholangiopancreatography
MRI	magnetic resonance imaging
MUGA	'multiple gated acquisition' cardiac nuclear scan
MWA	microwave ablation
NaF	sodium fluoride
NET	neuroendocrine tumor
NCCN®	National Comprehensive Cancer Network
NHL	non-Hodgkin's lymphoma
NPC	nasopharyngeal carcinoma
NSABP	National Surgical Adjuvant Breast and Bowel Project
NSAIDS	nonsteroidal anti-inflammatory drugs
NSCLC	non-small cell lung cancer
NSGCT	non-seminomatous germ cell tumor
PA	posteroanterior
PCI	prophylactic cranial irradiation
PET	positron emission tomography
COG	Children's Oncology Group
PSA	prostate specific antigen
RFA	radiofrequency ablation
RPLND	retroperitoneal lymph node dissection
SqCCa	squamous cell carcinoma
SCLC	small cell lung cancer
SIADH	syndrome of inappropriate secretion of antidiuretic hormone
TCC	transitional cell carcinoma
TLH	total laparoscopic hysterectomy
TNM	tumor node metastasis staging system
TSH	thyroid-stimulating hormone

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Abbreviations for Oncology Imaging Guidelines	
TURBT	trans-urethral resection of bladder tumor
VIPoma	vasoactive intestinal polypeptide
WLE	wide local incision
WB-MRI	whole body MRI
WM	Waldenstrom's macroglobulinemia
WBXRT	whole brain radiation therapy

Oncology Imaging Guidelines

General Criteria (ONC-1.0)

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General Criteria

- A relevant clinical evaluation or meaningful contact (telephone call, electronic mail or messaging) should be performed prior to considering advanced imaging, unless the individual is undergoing guideline-supported scheduled off therapy surveillance evaluation or cancer screening. The clinical evaluation may include a relevant history and physical examination, including biopsy, appropriate laboratory studies, and results of non-advanced or advanced imaging modalities.
- Unless otherwise stated in the disease-specific guideline, a histological confirmation of malignancy (or recurrence) and the stage of disease is required to perform a medical necessity review of the requested imaging.
- Generally, the studies listed in the disease-specific sections reflect the studies supported by current literature and research for that condition. If a study is not listed, then it is not considered medically necessary.
- Routine imaging of brain, spine, neck, chest, abdomen, pelvis, bones, or other body areas is not considered medically necessary except where explicitly stated in a diagnosis-specific guideline section, or if one of the following applies:
  - known prior disease involving the requested body area
  - new or worsening symptoms or physical exam findings involving the requested body area (including non-specific findings such as ascites or pleural effusion)
  - new finding on basic imaging study such as plain x-ray or ultrasound
  - new finding on adjacent body area CT/MRI study (e.g.,, pleural effusion observed on CT Abdomen)
- Unless otherwise stated in the disease-specific guideline, advanced imaging of asymptomatic individuals is not routinely considered medically necessary without signs or symptoms of systemic involvement of cancer.
- Repeat imaging studies are not generally considered medically necessary unless there is evidence of disease progression, recurrence of disease, and/or the repeat imaging will affect an individual's clinical management.
- Conventional imaging performed prior to diagnosis should not be repeated unless there is a delay of at least 6 weeks since previous imaging and treatment initiation or there are new or significantly worsening clinical signs or symptoms.
- If an individual is late for a specified imaging, the imaging may be approved late. However, the interval between the late imaging and the subsequent imaging must adhere to the interval in the disease-specific guidelines.

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Phases of Oncology Imaging and General Phase-Related Criteria

The following provides general clarity regarding the categories used to describe the phases of imaging throughout these guidelines.

- Screening
  - imaging requested for individuals at increased risk for a particular cancer in the absence of known clinical signs or symptoms
- Suspected diagnosis
  - imaging requested to evaluate a suspicion of cancer, prior to histological confirmation
- Initial work-up and staging
  - imaging requested after biopsy confirmation and prior to starting specific treatment
- Treatment response
  - imaging performed during active treatment with chemotherapy, targeted therapy, immunotherapy, radiation therapy, or endocrine therapy. Can be curative or non-curative.
- Restaging of locally treated lesions
  - imaging performed to evaluate response to primary or metastatic lesion(s) following lesion directed therapy (e.g. cryotherapy, ablation, radioembolization, chemoembolization, radiation therapy)
- Restaging/suspected recurrence
  - imaging requested when there is suspicion for progression or recurrence of known cancer based on clinical signs or symptoms, laboratory tests, or basic imaging studies
- Surveillance
  - imaging performed in individuals who are asymptomatic or have chronic stable symptoms, have no clinical suspicion of change in disease status, and are not receiving active anti-tumor treatment or are receiving maintenance treatment
  - In malignancies that support post-operative imaging through Restaging/ Recurrence or Surveillance guidelines, imaging interval is determined using both parameters. Surveillance imaging should be done using date of post-operative imaging. If post-operative imaging was not done, use most appropriate guideline.

The table below provides descriptions of treatment phases, their definitions, and general timeframes.

Treatment Phase	Phase Definition	Imaging Timeframe
After definitive local therapy of primary tumor	Treatment intended to be curative typically using a combination of surgery, radiation therapy, and chemotherapy	Follow surveillance guidelines
During/after neoadjuvant chemotherapy	Treatment given prior to definitive intended curative therapy (usually surgery and/or radiation therapy based), to shrink the cancer to make the definitive curative therapy more effective	Follow initial work-up/staging or restaging/recurrence
During adjuvant chemotherapy	Adjuvant is given after the primary cancer treatment (primary treatment is usually surgery or radiation) with the goal of destroying any remaining cancer cells that cannot be visualized but may still be present, to reduce the risk of recurrence and improve cure/ survival rates beyond initial curative treatments (e.g., colorectal, breast)	Follow surveillance guidelines
After ablative therapy	Minimally invasive medical procedure that destroys abnormal tissue (cancer cells) using heat, cold or other methods, often used as an alternative to surgery or in conjunction with other treatments. Ablative therapy can be considered curative or palliative depending on numerous factors such as other sites of disease, cancer subtype, and ablative technique used.	See disease-specific guidelines

Treatment Phase	Phase Definition	Imaging Timeframe
Chemotherapy or immunotherapy for active disease	• Measurable disease: Cancerous lesions that can be accurately measured in size to allow for assessment of tumor response. Solid lesions need to be 1cm or greater while lymph nodes should be 1.5cm or greater (short axis) • Non-measurable active disease: Lesions that cannot be accurately measured based on size (see above) in addition to lesions such as bone, pleural effusions, ascites, and carcinomatosis • Active disease: Cancer thought to be "active" whether it is measurable or non-measurable. For lesions that are not clear (i.e., due to small size, chronically stable, not proven to be malignant), provider discretion is to be used to include modality.	Every 2 cycles (generally every 6 to 8 weeks)
During endocrine/ hormonal therapy alone for active disease	E.g., tamoxifen, letrozole, anastrozole, exemestane	Every 3 months (12 weeks)
Active disease on maintenance therapy	Maintenance therapy is given to help keep cancer from coming back after it has shrunk or disappeared following initial therapy and may be given for a finite or indefinite timeframe	See disease-specific guidelines
Active metastatic disease being monitored off therapy		Every 3 months (12 weeks)

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Treatment Phase	Phase Definition	Imaging Timeframe
Metastatic disease in complete response on or off therapy	Defined as all measurable and non-measurable disease has disappeared (to include normalized tumor markers if applicable) and rarely translates into cure but remission can be sustained for years	• Once complete remission (CR) has been achieved, frequency of imaging should be no sooner than every 3 months and continue for up to 5 years from the time of CR • Follow surveillance guidelines
Metastatic disease in complete response due to definitive treatment (surgery, XRT, ablation) agnostic to histology	Defined as all measurable disease has been definitively removed/treated but individual is not considered cured	See disease-specific guideline; if not in guideline, determined on a case-by-case basis.
Metastatic disease in definitive remission after curative therapy (surgery, radiation, ablation)	Defined as metastatic disease (isolated/oligometastatic) that has been able to undergo definitive therapy of all sites of disease with intention of cure and no current signs or symptoms of active cancer	See disease-specific guideline

General Criteria

- Advanced imaging is not considered medically necessary for evaluation of in situ or non-invasive cancers or cancer surveillance after complete surgical removal of primary disease unless otherwise stated in the cancer-specific guidelines.
- Advanced imaging is not considered medically necessary for monitoring disease in individuals who choose to not receive standard oncologic therapy but may be receiving alternative therapies or palliative care and/or hospice. All advanced imaging considered medically necessary for initial staging of the specific cancer type can be approved once when the individual is considering initiation of a standard therapeutic approach (surgery, chemotherapy, or radiation therapy).
- Brain imaging is performed for signs or symptoms of brain disease

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  - MRI Brain without and with contrast (CPT® 70553) is the recommended study for evaluation of suspected or known brain metastases. If a non-contrast CT head shows suspicious lesion, MRI Brain is considered medically necessary to further characterize the lesion.
  - CT without and with contrast (CPT® 70470) is considered medically necessary when MRI is contraindicated or not available, or if there is skull bone involvement.
  - Certain malignancies including, but not limited to, melanoma and lung cancer have indications for brain imaging for asymptomatic individuals.
  - If stage IV disease is demonstrated elsewhere or if systemic disease progression is noted, refer to disease specific guidelines.
  - Initiation of angiogenesis therapy is not an indication for advanced imaging of the brain in asymptomatic individuals (Avastin/Bevacizumab; less than 3% risk of bleeding and less than 1% risk of serious bleeding).
- Bone Scan:
  - Primarily used for evaluation of bone metastases in individuals with solid malignancies.
  - Bone scan MAY be considered medically necessary in individuals with history of malignancy including bone pain, rising tumor markers, elevated alkaline phosphatase or in individuals with primary bone tumor.
  - For evaluation of suspected or known bony metastases, CPT® 78306 (Nuclear bone scan whole body), is considered medically necessary.
  - Radiopharmaceutical Localization scan SPECT (CPT® 78803 or CPT® 78831) or SPECT/CT (CPT® 78830 or CPT® 78832) is considered medically necessary as an add-on test for further evaluation of a specific area of interest.
  - CPT® codes 78300 (Nuclear bone scan limited), 78305 (Nuclear bone scan multiple areas) or 78315 do not have any indications in oncology nuclear medicine imaging.
- Bone scan supplemented by plain x-rays are the initial imaging modalities for suspected malignant bone pain. For specific imaging indications, see also:
  - **Bone (Non-Vertebral) Metastases (ONC-31.5)**
  - **Spinal/Vertebral Metastases (ONC-31.6)**
  - **Carcinoma of Unknown Primary Site (ONC-31.7)**
- Advanced imaging used for radiation therapy treatment planning should not be authorized using any of the diagnostic imaging codes for CT, MRI, or PET.
  - Advanced imaging performed in support of radiation therapy treatment planning should be reported with CPT® 76498 for Unlisted MRI or CPT® 76497 for Unlisted CT scan
- Delay PET/CT for at least 12 weeks after completion of radiation treatment, unless required sooner for imminent surgical resection.

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- PET/CT may be considered medically necessary prior to biopsy in order to determine a more favorable site for biopsy when a prior biopsy was nondiagnostic or a relatively inaccessible site is contemplated which would require invasive surgical intervention for biopsy attempt.
- Unless otherwise specified in diagnosis-specific guideline section, PET/CT is considered medically necessary if:
  - Conventional imaging (CT, MRI or bone scan) reveals findings that are inconclusive (including signs or symptoms that are highly suspicious for recurrence with no source found on imaging), with continued suspicion for active disease
- Unless specified in diagnosis-specific guideline section PET/CT imaging is NOT considered medically necessary for:
  - infection, inflammation, trauma, post-operative healing, granulomatous disease, rheumatological conditions
  - concomitant use with separate diagnostic CT studies
  - conclusive evidence of distant or diffuse metastatic disease on recent conventional imaging studies
  - metastatic disease in the central nervous system (CNS)
  - lesions less than 8 mm in size
  - follow up after localized therapy (e.g., radiofrequency ablation, embolization, stereotactic radiation, etc.)
  - rare malignancies, due to lack of available evidence regarding the diagnostic accuracy of PET in rare cancers
  - surveillance
    - Serial monitoring of individuals who are not currently receiving anti-tumor treatment or are receiving maintenance treatment
    - Serial monitoring of FDG avidity until resolution
    - PET/CT avidity in a residual mass at the end of planned therapy is not an indication for PET/CT imaging during surveillance
    - Residual mass that has not changed in size since the last conventional imaging does not justify PET imaging
- Unless otherwise specified for a specific cancer type, once PET has been documented to be negative for a given individual's cancer or all PET-avid disease has been surgically resected, PET is not considered medically necessary for continued disease monitoring or surveillance.
- PET/MRI is generally not considered medically necessary by for a vast majority of oncologic conditions due to lack of standardization in imaging technique and interpretation. However, it may be approved in select circumstances when the following criteria are met:
  - the individual meets condition-specific guidelines for PET/MRI OR
  - the individual meets ALL of the following:

        - The individual meets guideline criteria for PET/CT, AND
        - PET/CT is not available at the treating institution, AND
        - The provider requests PET/MRI in lieu of PET/CT
    - When the above criteria are met, PET/MRI may be reported using the code combination of PET Whole-Body (CPT® 78813) and MRI Unlisted (CPT® 76498). All other methods of reporting PET/MRI are inappropriate.
        - When clinically appropriate, diagnostic MRI codes may be considered medically necessary at the same time as the PET/MRI code combination.
- The specific radiotracer planned to be used with PET/CT imaging is required to perform a medical necessity review. Indications for PET/CT imaging using non-FDG radiotracers are listed in diagnosis-specific guidelines.
    - supported radiotracers:
        - ^{18}F-FDG
        - ^{68}Ga-DOTATATE (NETSPOT®) for low-grade neuroendocrine tumors and medullary thyroid cancer
        - ^{64}Cu-DOTATATE (DETECTNET®) for low-grade neuroendocrine tumors
        - ^{68}Ga-DOTA-TOC for low-grade neuroendocrine tumors
        - ^{11}C Choline for prostate cancer
        - ^{18}F-Fluciclovine (AXUMIN®) for prostate cancer
        - ^{68}Ga PSMA-11 for prostate cancer
        - ^{18}F Piflufolastat (Pylarify®) for prostate cancer
        - ^{68}Ga Gozetotide (Illuccix®,Locametz®, and Gozellix®) for prostate cancer
        - ^{18}F Flotufolastat (Posluma®) for prostate cancer
        - ^{18}F Fluoroestradiol (Cerianna®) for breast cancer
        - ^{18}F Na Fluoride PET bone scan for breast cancer and prostate cancer
    - unsupported radiotracers:
        - PET/CT imaging using isotopes other than those specified above
- Octreotide scan:
    - Specific for low and intermediate grade neuroendocrine tumors which express specific cell surface somatostatin receptors. See cancer specific guidelines for recommended use.
    - One of the following codes may be approved when Octreotide scan is requested:
    - CPT® 78802 (Radiopharmaceutical localization of tumor whole-body single day study)
    - CPT® 78804 (Radiopharmaceutical localization of tumor whole-body two or more days)
    - In addition to one of the above CPT codes, CPT® 78803 (Radiopharmaceutical localization of tumor SPECT), SPECT CPT® 78831, or hybrid SPECT/CT (CPT® 78830 or 78832) may be approved as an add-on test for further evaluation of

Oncology Imaging Guidelines

a specific area of interest or clinically suspected lesions with negative whole body bone scan or documented bone metastasis in the setting of inconclusive or negative findings.

Clinical Trials

- Similar to investigational and experimental studies, clinical trial imaging requests will be considered to determine whether they meet these evidence-based guidelines.
- Imaging studies which are inconsistent with established clinical standards, or are requested for data collection and not used in direct clinical management are not considered medically necessary.

Health Equity Considerations

Health equity is the highest level of health for all individuals; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which individuals are born, grow, live, work, and age. Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include the following: safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Key Principles (ONC-1.1)

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AGE APPROPRIATE GUIDELINES	
Age of Individual	**Appropriate Imaging Guidelines**
19 years of age or older at initial diagnosis	• General Oncology Imaging Guidelines, except where directed otherwise by a specific guideline section
Under 19 years of age at initial diagnosis	• Pediatric and Special Populations Oncology Imaging Guidelines, except where directed otherwise by a specific guideline section
15 to 39 years old at initial diagnosis (defined as Adolescent and Young Adult (AYA) oncology individuals)	• When unique guidelines for a specific cancer type exist only in either General Oncology or Pediatric and Special Populations Oncology, AYA individuals should be imaged according to the guideline section for their specific cancer type, regardless of the individual's age • When unique guidelines for a specific cancer type exist in both General Oncology and Pediatric and Special Populations Oncology, AYA individuals should be imaged according to the age rule in the previous bullet

Criteria

- Conventional imaging (mostly CT, sometimes MRI or bone scan) of the affected area(s) drives much of initial and re-staging and surveillance. PET is not considered medically necessary for surveillance imaging unless specifically stated in the diagnosis-specific guideline sections.
- Brain imaging is performed for signs or symptoms of brain disease.
  - MRI Brain without and with contrast (CPT® 70553) is the preferred study for evaluation of suspected or known brain metastases.
  - MRI Brain without and with contrast (CPT® 70553) is considered medically necessary if a non-contrast CT Head shows suspicious lesion.
  - CT Head without and with contrast (CPT® 70470) is considered medically necessary when MRI is contraindicated or not available, or if there is skull bone involvement.

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  - Initiation of angiogenesis therapy is not an indication for advanced imaging of the brain in asymptomatic individuals (Avastin/bevacizumab; less than 3% risk of bleeding and less than 1% risk of serious bleeding).
- Individuals receiving cardiotoxic chemotherapy (such as doxorubicin, trastuzumab, pertuzumab, mitoxantrone, etc.) may undergo cardiac evaluation - at baseline and for monitoring while on active therapy.
  - See: **Oncologic Indications for Cancer Therapeutics-Related Cardiac Dysfunction (CTRCD) (CD-12.1)** in the Cardiology Imaging Guidelines
- CTA or MRA of a specific anatomic region is considered medically necessary when requested for surgical planning when there is suspected vascular proximity to proposed resection margin
- Screening adults (18 years of age or older) with a diagnosis of Li-Fraumeni Syndrome (LFS) for malignancy with a Whole-Body MRI (CPT® 76498) is considered medically necessary on an annual basis. Annual Brain MRI (CPT® 70553) may be performed as part of Whole-Body MRI or as a separate exam. Due to lack of standardization of technique, interpretation, and availability of Whole-Body MRI, individuals with LFS are encouraged to participate in clinical trials.

Use of Contrast Criteria

- CT imaging should be performed with contrast for known or suspected body regions, unless contraindicated.
  - Shellfish allergy is not a contraindication to contrast
  - For iodinated contrast dye allergy, either CT scans without contrast or MRI scan without and with contrast are considered medically necessary.
  - If CT scanning is considered medically necessary in an individual with known contrast allergy, CT with contrast may be considered to be safely performed following prednisone premedication over a 24-hour period prior to the study.
- Severe renal insufficiency (i.e., an eGFR less than 30) is a contraindication for an MRI using a gadolinium-based contrast agent (GBCA). In individuals with eGFR greater than 40, GBCA administration can be safely performed. GBCA administered to individuals with acute kidney injury or severe chronic kidney disease can result in a syndrome of nephrogenic systemic fibrosis (NSF), but GBCAs are not considered nephrotoxic at dosages approved for MRI.
- Gadolinium deposition has been found in individuals with normal renal function following the use of GBCAs.
  - The U.S. Food and Drug Administration (FDA) is investigating the risk of brain deposits following repeated use of GBCAs.
  - The FDA has noted that, “It is unknown whether these gadolinium deposits are harmful or can lead to adverse health effects” and have recommended:

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- To reduce the potential for gadolinium accumulation, health care professionals should consider limiting GBCA use to clinical circumstances in which the additional information provided by the contrast is necessary.
- Health care professionals are also urged to reassess the necessity of repetitive GBCA MRIs in established treatment protocols

Radiation Exposure Criteria

The use of MRI in place of CT scans to reduce risk of secondary malignancy from radiation exposure during CT is not supported by the peer-reviewed literature. Unless otherwise specified in the Guidelines or in pregnant individuals as noted below, MRI in place of CT scans for this purpose alone is not considered medically necessary. In some instances (i.e., testicular cancer surveillance), MRI may be considered inferior to CT scans.

- For pregnant individuals, ultrasound or MRI may be obtained as first-line imaging as requested to reduce radiation exposure.

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PET Imaging in Oncology (ONC-1.4)

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Criteria

- CPT codes:
  - PET Imaging in oncology should use PET/CT fusion (CPT® 78815 or CPT® 78816). Unbundling PET/CT imaging into separate PET and diagnostic CT codes is otherwise not considered medically necessary.
  - "Limited area" protocol is done infrequently, but may be considered medically necessary, and is reported with PET (CPT® 78811) or for PET/CT (CPT® 78814).
- Radiotracers:
  - Unless specified otherwise, the term "PET" refers to ^{18}F-FDG-PET and PET/CT fusion studies
  - Indications for PET/CT imaging using non-FDG radiotracers are listed in diagnosis-specific guidelines. The indications may be as follows:
- Supported radiotracers:
  - ^{18}F-FDG
  - ^{68}Ga-DOTATATE (NETSPOT®) for low-grade neuroendocrine tumors and medullary thyroid cancer
  - ^{64}Cu-DOTATATE (DETECTNET®) for low-grade neuroendocrine tumors
  - ^{68}Ga-DOTA-TOC for low-grade neuroendocrine tumors
  - ^{11}C Choline for prostate cancer
  - ^{18}F-Fluciclovine (AXUMIN®) for prostate cancer
  - ^{68}Ga PSMA-11 for prostate cancer
  - ^{18}F Piflufolastat (Pylarify®) for prostate cancer
  - ^{68}Ga Gozetotide (Illuccix®, Locametz®, and Gozellix®) for prostate cancer
  - ^{18}F Flotufolastat (Posluma®) for prostate cancer
  - ^{18}F Fluoroestradiol (Cerianna®) for breast cancer
  - ^{18}F Na Fluoride PET bone scan for breast cancer and prostate cancer
- Unsupported radiotracers:
  - PET/CT imaging using isotopes other than those specified above

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CPT/ HCPCS Code	Code Description	Brand or common name	Guideline Section and Cancer Type
A9552	^{18}F Fluoro deoxyglucose	FDG	Various guideline sections where PET is indicated
A9580	^{18}F Sodium fluoride	N/A	ONC-11: Breast Cancer, ONC-19: Prostate Cancer
A9587	^{68}Ga-68 Dotatate	NETSPOT®	ONC-15: Low-grade neuroendocrine tumors, ONC-6: Medullary thyroid cancer
A9515	^{11}C Choline	N/A	ONC-19, Prostate Cancer
A9588	^{18}F-Fluciclovine	AXUMIN®	ONC-19, Prostate Cancer
A9593 A9594	^{68}Ga PSMA-11	N/A	ONC-19, Prostate Cancer
A9595	^{18}F Piflufolastat	Pylarify®	ONC-19, Prostate Cancer
A9596	^{68}Ga Gozetotide	Illuccix®	ONC-19, Prostate Cancer
A9800	^{68}Ga Gozetotide	Locametz®	ONC-19, Prostate Cancer
A9616	^{68}Ga Gozetotide	Gozellix®	ONC-19, Prostate Cancer
A9608	^{18}F Flotufolastat	Posluma®	ONC-19, Prostate Cancer
A9591	^{18}F Fluoroestradiol	Cerianna®	ONC-11, Breast Cancer
A9592	^{64}Cu Copper dotatate	Detectnet®	ONC-15, Low-grade neuroendocrine tumors
C9067	^{68}Ga Gallium-DOTA-TOC	N/A	ONC-15, Low-grade neuroendocrine tumors

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- Unless specified in diagnosis-specific guideline section PET/CT imaging is not considered medically necessary for:
  - infection, inflammation, trauma, post-operative healing, granulomatous disease, rheumatologic conditions
  - concomitant use with separate diagnostic CT studies
  - conclusive evidence of distant or diffuse metastatic disease on recent conventional imaging studies
  - metastatic disease in the central nervous system (CNS)
  - lesions less than 8mm in size
  - follow up after localized therapy (i.e., radiofrequency ablation, embolization, stereotactic radiation, etc.)
  - rare malignancies, due to lack of available evidence regarding the diagnostic accuracy of PET in rare cancers
  - surveillance:
    - Serial monitoring of individuals who are not currently receiving anti-tumor treatment or are receiving maintenance treatment
    - Serial monitoring of FDG avidity until resolution.
    - PET/CT avidity in a residual mass at the end of planned therapy is not an indication for PET/CT imaging during surveillance.
    - Residual mass that has not changed in size since the last conventional imaging does not justify PET imaging
  - Unless otherwise specified for a specific cancer type, once PET has been documented to be negative for a given individual's cancer or all PET-avid disease has been surgically resected, PET should not be used for continued disease monitoring or surveillance.
- Unless otherwise specified in diagnosis-specific guideline section, PET/CT is considered medically necessary if:
  - Conventional imaging (CT, MRI or bone scan) reveals findings that are inconclusive (including signs or symptoms that are highly suspicious for recurrence with no source found on imaging), with continued suspicion for active disease.
  - The individual is undergoing salvage treatment for a recurrent solid tumor with residual measurable disease on conventional imaging and confirmed repeat negative PET imaging will allow the individual to transition from active treatment to surveillance.
  - PET/CT may be considered prior to biopsy in order to determine a more favorable site for biopsy when a prior biopsy was nondiagnostic or a relatively inaccessible site is contemplated which would require invasive surgical intervention for biopsy attempt.
- PET/CT for rare malignancies is not covered by these guidelines due to lack of available evidence regarding diagnostic accuracy of PET/CT in the majority of

rare cancers. Conventional imaging studies should be used for initial staging and treatment response for these diagnoses. PET/CT is considered medically necessary if all of the following apply:
  - Conventional imaging (CT, MRI or bone scan) reveals equivocal or suspicious findings.
  - No other specific metabolic imaging (MIBG, octreotide, technetium, etc.) is appropriate for the disease type.
  - The submitted clinical information describes a specific decision regarding the individual's care that will be made based on the PET/CT results.
- Delay PET/CT for at least 12 weeks after completion of radiation treatment, unless required sooner for imminent surgical resection.
- PET Mammography (PEM, generally reported with CPT® 78811) is considered experimental and investigational at this time.
- PET/MRI is generally not considered medically necessary for a vast majority of oncologic conditions due to lack of standardization in imaging technique and interpretation. However, it may be approved in select circumstances when the following criteria are met:
  - The individual meets condition-specific guidelines for PET/MRI OR
  - The individual meets ALL of the following:
    - The individual meets guideline criteria for PET/CT, AND
    - PET/CT is not available at the treating institution, AND
    - The provider requests PET/MRI in lieu of PET/CT
  - When the above criteria are met, PET/MRI may be reported using the code combination of PET Whole-Body (CPT® 78813) and MRI Unlisted (CPT® 76498). All other methods of reporting PET/MRI are inappropriate.
    - When clinically appropriate, diagnostic MRI codes may be indicated at the same time as the PET/MRI code combination.
    - PET/MRI Brain may be reported using the code combination of (CPT® 78811) and (CPT® 76498).

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Predisposition Syndromes (ONC-1.6)

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- For predisposition syndrome screening in adult individuals, see: **Screening Imaging in Cancer Predisposition Syndromes (PEDONC-2)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

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Unlisted Procedure Codes in Oncology (ONC-1.5)

ON.GG.0001.5.A
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Criteria

- There is often no unique procedure code for a service performed solely for treatment planning purposes. AMA instructions in the CPT® state that if no specific code exists for a particular service, the service is reported with an unlisted code.
- Advanced imaging being used for radiation therapy treatment planning should not be authorized using any of the diagnostic imaging codes for CT, MRI or PET. Advanced imaging performed in support of radiation therapy treatment planning should be reported with:
  - **CPT® 76498 for Unlisted MRI** – when MRI will be used for treatment planning of radiation therapy to be delivered ONLY to the brain, prostate and cervix. The use of this code for radiation treatment planning of any other cancers/body parts not listed above may be reviewed on a case-by-case basis. Also on a case-by-case basis, an additional diagnostic study may be considered medically necessary if there is an additional clinical question requiring reading and interpretation of the study by a diagnostic radiologist (i.e., the study is not used exclusively for radiation treatment planning).
  - **CPT® 76497 for Unlisted CT** – may NOT be used for radiation treatment planning. CT imaging performed in support of radiation therapy treatment planning is bundled in with the concurrent radiation treatment authorization codes and a separate authorization for treatment planning is not required.
  - Imaging associated with image-directed biopsy should be reported with the corresponding interventional codes.
  - For advanced imaging used solely for the purpose of Surgical planning, see: **Unlisted Procedures/Therapy treatment planning (Preface-4.3)** in the Preface Imaging Guidelines
  - CPT® 76376 and CPT® 76377 are not considered medically necessary for the standard radiation therapy treatment planning process.

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Primary Central Nervous System Tumors (ONC-2)

Guideline Page

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Primary Central Nervous System Tumors – General Considerations (ONC-2.1)

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Criteria

- This guideline section applies to primary CNS tumors only. For imaging guidelines in metastatic brain cancer, see the appropriate diagnosis-specific section or **Brain Metastases (ONC-31.3)** for imaging guidelines.
-
- Histologic confirmation is critical. Therapeutic decisions should not be made on radiographic findings alone, except for ANY of the following:
  - Medically fragile individuals for whom attempted biopsy carries excess medical risk, as stated in writing by both the attending physician and surgeon.
  - Brain stem tumors or other sites where the imaging findings are pathognomonic and the risk of permanent neurological damage is excessive with even a limited biopsy attempt
- For evaluation of known or suspected spinal cord compromise, see: **Spinal/Vertebral Metastases (ONC-31.6)**
- For suspected brain tumors in neurofibromatosis, see: **Screening Imaging in Cancer Predisposition Syndromes (PEDONC-2)** in the Pediatric and Special Populations Oncology Imaging Guidelines
- Rare tumors occurring more commonly in the pediatric population should be imaged according to the imaging guidelines in: **Pediatric Central Nervous System Tumors (PEDONC-4)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

Indication	Medically Necessary Imaging Study
Characterization and follow up of all brain tumors	ANY or ALL of the following: • MRI Brain without and with contrast (CPT® 70553) • CT Head without and with contrast (CPT® 70470) when MRI is contraindicated or not available, or there is skull bone involvement • CT Head (contrast as requested) for preoperative planning when requested by the operating surgeon

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Indication	Medically Necessary Imaging Study
Preoperative planning or to clarify inconclusive findings on MRI or CT in individuals with primary CNS tumors	• MRA Head (CPT® 70544) or CTA Head (CPT® 70496)
Within 24 to 72 hours following brain tumor surgery in individuals with primary CNS tumors	• MRI Brain without and with contrast (CPT® 70553)
Clinical deterioration or development of new neurological features in individuals with primary CNS tumors	• MRI Brain without and with contrast (CPT® 70553) • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) for signs/symptoms of spinal involvement or if spinal involvement is suspected

MR Spectroscopy Criteria in Brain Tumors (MRS, CPT® 76390)

- MRS is only considered medically necessary for use in brain tumors of specified histologies where diagnostic accuracy has been established in peer-reviewed literature.
  - See diagnosis-specific guidelines for MRS indications
- MRS is considered not medically necessary for all other histologies and indications not listed in a diagnosis-specific guideline section.

PET Brain Imaging Criteria (CPT® 78608 and CPT® 78609)

- PET Brain Metabolic Imaging (CPT® 78608) is considered not medically necessary for all other histologies and indications not listed in a diagnosis-specific guideline section in individuals with primary CNS tumors.
- PET Brain Perfusion Imaging (CPT® 78609) is not considered medically necessary in the evaluation or management of primary CNS tumors.
- Body PET studies (CPT® 78811, CPT® 78812, and CPT® 78813) and fusion PET/CT studies (CPT® 78814, CPT® 78815, or CPT® 78816) are not considered medically necessary in the evaluation or management of primary CNS tumors.
- See: **Other Imaging Studies (HD-24)** in the Head Imaging Guidelines for details on other advanced neuro-imaging studies.

Background and Supporting Information

Primary central nervous system (CNS) tumors are neoplasms arising from brain parenchyma, cranial nerves, meninges, or supporting structures, and are distinct from secondary (metastatic) intracranial disease. Primary CNS tumors account for 1.4% of all new cancer diagnoses in the United States and 2.7% of deaths due to cancer. Contemporary classification of primary CNS tumors is based on an integrated histologic and molecular framework, as defined by the World Health Organization (WHO) Classification of Tumors of the Central Nervous System, Fifth Edition (CNS5). This system incorporates histopathologic features together with molecular alterations to define biologically and clinically meaningful tumor entities and grades, which directly inform prognosis and management (Louis et al., 2021). Low grade tumors (WHO I, II) are the most common primary brain tumors (71.7% of all tumors). High grade tumors (WHO II/IV) account for 28.3% of all tumors. Meningioma is the most common low grade tumor accounting for 39.7% of all tumors. Glioblastoma is the most common malignant glioma accounting for 15.4% of all tumors.

Histologic confirmation is fundamental to the diagnosis and management of primary CNS tumors. Molecular profiling, including markers such as IDH mutation status, 1p/19q codeletion, ATRX loss, and H3 alterations, is now considered an essential component of tumor characterization rather than an adjunctive test. This approach is supported by international consensus and clinical practice guidelines, which emphasize that therapeutic decisions should not be based on imaging findings alone except in limited, well-defined circumstances where biopsy poses unacceptable risk or imaging features are pathognomonic (Louis et al., 2021; NCCN, 2026).

Evidence Discussion

The clinical criteria supporting imaging evaluation of primary CNS tumors are grounded in evidence demonstrating that accurate anatomic and biologic characterization is critical to optimizing outcomes while minimizing unnecessary risk. MRI with and without contrast provides superior soft-tissue contrast and sensitivity for intracranial tumors compared with CT, particularly for posterior fossa lesions, multifocal disease, and leptomeningeal involvement. Multiple guideline bodies emphasize MRI as the preferred modality because it directly informs diagnosis, surgical planning, and post-treatment assessment (NCCN, 2026; NICE, 2021).

Requiring histologic confirmation whenever feasible reflects strong evidence that imaging features alone cannot reliably distinguish among CNS tumor subtypes or predict molecular characteristics that drive prognosis and therapy. Integrated histologic–molecular classification has been shown to outperform imaging-based assessment in predicting clinical behavior and treatment response. Exceptions to tissue diagnosis are limited to scenarios in which biopsy carries excessive risk or is unlikely to alter

management, thereby balancing diagnostic benefit against potential harm (Louis et al., 2021; NCCN, 2026).

Advanced imaging modalities offer incremental benefit in selected circumstances but also introduce potential harms, including increased scan time, interpretive complexity, and risk of misclassification when applied indiscriminately. Evidence supports the selective use of MR perfusion and MR spectroscopy in specific tumor types to aid in distinguishing viable tumor from treatment effects and in identifying areas of highest tumor grade for biopsy. However, inconsistent diagnostic performance across histologies and dependence on technical expertise limit their role to narrowly defined indications (ACR, 2016; ACR, 2017; Mabray et al., 2015).

Similarly, metabolic brain PET imaging has shown utility in selected primary CNS tumor histologies but lacks sufficient evidence to support routine use across all tumor types. Body PET imaging and perfusion PET of the brain have not demonstrated clinical benefit in the evaluation or management of primary CNS tumors and expose patients to unnecessary radiation without clear impact on outcomes. Restricting these modalities aligns evidence-based benefit with patient safety, resource stewardship, and avoidance of diagnostic harm (Kong et al., 2018; NCCN, 2026; NICE, 2021).

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Low Grade Gliomas (ONC-2.2)

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Criteria

- These tumors are defined as having a World Health Organization (WHO) histologic grade of I or II (out of IV), can occur anywhere in the CNS, and includes the following:
  - Diffuse low-grade gliomas
    - Fibrillary (or Diffuse) Astrocytoma
    - Angiocentric glioma
  - Circumscribed astrocytic gliomas
    - Pilocytic Astrocytoma
    - High-grade astrocytoma with piloid features
    - Pleomorphic xanthoastrocytoma
    - Pilomyxoid Astrocytoma
    - Oligoastrocytoma
    - Subependymal Giant Cell Astrocytoma (SEGA)
    - Choroid glioma
    - Astroblastoma, MN
  - Glioneuronal and neuronal tumors
    - Ganglioglioma
    - Gangliocytoma
    - Gangliоglioneuroma
    - Diffuse glioneuronal tumor with oligodendroglioma-like features and nuclear clusters
    - Papillary glioneuronal tumor
    - Rosette-forming glioneuronal tumor
    - Myxoid glioneuronal tumor
    - Diffuse leptomeningeal glioneuronal tumor
    - Gangliocytoma Multinodular and vacuolating neuronal tumor
    - Dysplastic cerebellar gangliocytoma (Lhermitte-Duclos disease)
    - Central neurocytoma
    - Extraventricular neurocytoma
    - Cerebellar liponeurocytoma
  - Optic Pathway Gliomas
  - Oligodendroglioma
  - Oligodendrocytoma
  - Dysembryoplastic infantile astrocytoma (DIA)

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- Dysembryoplastic infantile ganglioglioma (DIG)
- Dysembryoplastic neuroepithelial tumor (DNT)
- Tectal plate gliomas
- Cervicomedullary gliomas
- Pleomorphic xanthoastrocytoma (PXA)
- Any other glial tumor with a WHO grade of I or II classification

Indication	Medically Necessary Imaging Study
Initial staging of low grade gliomas	• MRI Brain without and with contrast (CPT® 70553) if not already done • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) ◦ MRI Spine with contrast only (Cervical-CPT® 72142, Thoracic-CPT® 72147, Lumbar-CPT® 72149) if being performed immediately following a contrast-enhanced MRI Brain
After initial resection or other treatment (radiation therapy, etc.) in individuals with low grade gliomas	• MRI Brain without and with contrast (CPT® 70553)
For individuals with low grade gliomas undergoing chemotherapy treatment	• MRI Brain without and with contrast (CPT® 70553) every 2 cycles • Individuals with spinal cord involvement at diagnosis can have MRI without and with contrast of the involved spinal region on the same schedule as MRI brain
ONE of the following in individuals with low grade gliomas: • Determine need for biopsy when transformation to high-grade glioma is suspected based on clinical symptoms or recent MRI findings • Evaluate a brain lesion of indeterminate nature when the study will be used to determine whether biopsy/resection can be safely postponed	ANY of the following: • PET Brain Metabolic Imaging (CPT® 78608) • MRI Perfusion imaging (CPT® 70553)

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Indication	Medically Necessary Imaging Study
ONE of the following in individuals with low grade gliomas: • Distinguish low-grade from high-grade gliomas • Evaluate a brain lesion of indeterminate nature when the study will be used to determine whether biopsy/resection can be safely postponed • Distinguish radiation-induced tumor necrosis from progressive disease within 18 months of completing radiotherapy	ANY of the following: • MR Spectroscopy (CPT® 76390) • MRI Perfusion imaging (CPT® 70553)
Suspected intracranial or intraspinal recurrence in individuals with low grade gliomas	• All imaging considered medically necessary for initial staging
Surveillance, grade I gliomas	• MRI Brain without and with contrast (CPT® 70553) every 3 months for up to 5 years • Individuals with spinal cord involvement at diagnosis: MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) on the same schedule as MRI Brain
Surveillance, grade II gliomas (Karnofsky Performance Score greater than or equal to 60, not poor performance status as below)	• MRI Brain without and with contrast (CPT® 70553) every 3 months for 5 years, then every 6 months thereafter • Individuals with spinal cord involvement at diagnosis: MRI Spine without and with contrast (Cervical- CPT® 72156, Thoracic- CPT® 72157, Lumbar- CPT® 72158) on the same schedule as MRI Brain

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Indication	Medically Necessary Imaging Study
Surveillance, grade II gliomas and poor performance status (Karnofsky Performance Score less than 60)	• MRI Brain without and with contrast (CPT® 70553) every 2 months for 3 years, then every 3 months thereafter • Individuals with spinal cord involvement at diagnosis: MRI Spine without and with contrast (Cervical- CPT® 72156, Thoracic- CPT® 72157, Lumbar- CPT® 72158) on the same schedule as MRI Brain

Background and Supporting Information

Low grade gliomas are primary central nervous system tumors defined by a World Health Organization (WHO) histologic grade of I or II. These tumors arise from glial or mixed neuronal-glial cells and may occur throughout the brain and spinal cord. The category encompasses a heterogeneous group of entities, including pilocytic astrocytoma, fibrillary (or diffuse) astrocytoma, optic pathway gliomas, pilomyxoid astrocytoma, oligodendroglioma, oligoastrocytoma, oligodendeocytoma, subependymal giant cell astrocytoma (SEGA), ganglioglioma, gangliocytoma, dysembryoplastic infantile astrocytoma (DIA), dysembryoplastic infantile ganglioglioma (DIG), dysembryoplastic neuroepithelial tumor (DNT), tectal plate gliomas, cervicomedullary gliomas, pleomorphic xanthoastrocytoma (PXA), and any other glial tumor with a WHO grade of I or II (Louis et al., 2021).

Low grade gliomas often demonstrate indolent growth but are associated with long-term risks of progression, malignant transformation, and treatment-related morbidity. Tumors may disseminate via cerebrospinal fluid pathways, particularly in pediatric and midline or optic pathway gliomas, making assessment of the entire neuraxis clinically relevant at diagnosis. Functional status, often measured using performance scales such as the Karnofsky Performance Score, is a recognized prognostic factor and influences monitoring intensity and management strategies (NCCN, 2026).

Evidence Discussion

The imaging approach for low grade gliomas balances the need for thorough disease assessment with the goal of minimizing patient risk and unnecessary testing. MRI of the brain provides high sensitivity for tumor detection, anatomic delineation, and assessment of postoperative or post-treatment change. Inclusion of spinal MRI during initial staging is supported by evidence that leptomeningeal spread, although uncommon, significantly affects prognosis and management, particularly in pediatric low

grade gliomas and tumors with midline or ventricular involvement (NCCN, 2026; NICE, 2021).

Establishing a post-treatment imaging baseline following resection, radiation, or other therapy is clinically important for distinguishing treatment-related effects from residual or recurrent disease on subsequent studies. During active therapy, interval MRI assessments allow for timely detection of progression or complications and may guide modification of therapy. Patients with poorer performance status are at increased risk for clinical deterioration, supporting closer imaging surveillance to promptly identify actionable changes (NCCN, 2026).

Advanced imaging modalities provide additional biologic information but have limitations that preclude routine use. MR perfusion imaging can reflect tumor vascularity and has demonstrated value in identifying malignant transformation or distinguishing progression from treatment effect. MR spectroscopy can assist in differentiating low-grade from higher-grade lesions and in evaluating suspected radiation necrosis. However, variability in acquisition, interpretation, and diagnostic performance across tumor types necessitates restricting these techniques to well-defined clinical indications to avoid misclassification and overtreatment (ACR, 2016; ACR, 2017; Mabray et al., 2015).

Similarly, brain metabolic PET imaging may support decision-making in select cases by helping identify higher-grade components or guiding biopsy when transformation is suspected. Evidence does not support routine use of PET or whole-body imaging in low grade gliomas, as these approaches add radiation exposure and cost without demonstrable benefit in most patients. Limiting advanced imaging to problem-solving scenarios aligns clinical benefit with patient safety and evidence-based resource utilization (Kong et al., 2018; NICE, 2021).

Health Equity Considerations

Low-grade gliomas (LGGs) exhibit clinically meaningful variation in incidence, tumor characteristics, and outcomes across demographic groups, underscoring the relevance of health equity considerations in diagnostic and longitudinal imaging. Population-level analyses demonstrate that survival outcomes for LGG differ by age, sex, race, and ethnicity, with older age at diagnosis independently associated with poorer disease-specific survival (Cao et al., 2023). Differences in tumor biology, clinical presentation, and disease trajectory across demographic groups may influence prognosis and the intensity and frequency of imaging surveillance over time. These variations highlight the importance of applying consistent, evidence-based imaging strategies for LGG diagnosis and follow-up to support accurate risk stratification and timely clinical decision-making across diverse patient populations.

Sociodemographic and structural determinants of health further contribute to inequities in LGG care and outcomes. Patients from lower socioeconomic backgrounds and

historically marginalized racial and ethnic groups report worse health-related quality of life and encounter greater barriers to specialty neuro-oncologic care, including delays in advanced neuroimaging, reduced continuity of surveillance, and limited access to supportive services (Perez et al., 2026). Given the prolonged clinical course of LGGs and reliance on serial imaging to guide management, inconsistent access to guideline-concordant imaging may exacerbate disparities through delayed detection of progression or fragmented follow-up. Standardized imaging recommendations aim to reduce unwarranted variation in care delivery, and attention to known disparities in access and outcomes is essential to ensure that LGG imaging is applied equitably, particularly for patients at higher risk of delayed presentation, interrupted surveillance, or under-treatment (Cao et al., 2023; Perez et al., 2026).

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High Grade Gliomas (ONC-2.3)

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v1.0.2027

Criteria

- These tumors are defined as having a WHO histologic grade of III or IV (out of IV can occur anywhere in the CNS (though the majority occur in the brain), and include the following tumors:
  - Anaplastic astrocytoma
  - Glioblastoma multiforme
  - Diffuse intrinsic pontine glioma (DIPG, or “brainstem glioma”)
  - Gliomatosis cerebri
  - Gliosarcoma
  - Anaplastic oligodendroglioma
  - Anaplastic ganglioglioma
  - Anaplastic mixed glioma
  - Anaplastic mixed ganglioneuronal tumors
  - Any other glial tumor with a WHO grade of III or IV

Indication	Medically Necessary Imaging Study
Initial staging of high grade gliomas	• MRI Brain without and with contrast (CPT® 70553) if not already done • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) ◦ MRI Spine with contrast only (Cervical-CPT® 72142, Thoracic-CPT® 72147, Lumbar-CPT® 72149) if being performed immediately following a contrast-enhanced MRI Brain
Immediately following partial or complete resection in individuals with high grade gliomas	• MRI Brain without and with contrast (CPT® 70553)
Immediately following radiation therapy (XRT) in individuals with high grade gliomas	• MRI Brain without and with contrast (CPT® 70553) once within 2 to 8 weeks following completion of treatment, and then go to surveillance imaging

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Indication	Medically Necessary Imaging Study
For individuals with high grade gliomas undergoing chemotherapy treatment	• MRI Brain without and with contrast (CPT® 70553) every 2 cycles • Individuals with spinal cord involvement at diagnosis: MRI without and with contrast of the involved spinal region on the same schedule as MRI Brain
ONE of the following in individuals with high grade gliomas: • Distinguish low-grade from high-grade gliomas • Evaluate a brain lesion of indeterminate nature when the study will be used to determine whether biopsy/resection can be safely postponed • Distinguish radiation-induced tumor necrosis from progressive disease within 18 months of completing radiotherapy	ANY of the following: • MR Spectroscopy (CPT® 76390) • MRI Perfusion imaging (CPT® 70553)
ONE of the following in individuals with high grade gliomas: • Distinguish radiation-induced tumor necrosis from progressive disease • Evaluate inconclusive MRI findings when the study will be used to determine need for biopsy or change in therapy, including a change from active therapy to surveillance • Evaluate a brain lesion of indeterminate nature when the study will be used to determine whether biopsy/resection can be safely postponed	ANY of the following: • MRI Perfusion imaging (CPT® 70553) • PET Brain metabolic imaging (CPT® 78608) ◦ PET Brain is not considered medically necessary in gliomas occurring in the brain stem due to poor uptake and lack of impact on individual outcomes

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Indication	Medically Necessary Imaging Study
Suspected intracranial or intraspinal recurrence in individuals with high grade gliomas	• All imaging is considered medically necessary for initial staging
Surveillance in individuals with high grade gliomas	• MRI Brain without and with contrast (CPT® 70553) every 2 months for 3 years and every 3 months thereafter • Individuals with spinal cord involvement at diagnosis: MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) on the same schedule as MRI Brain

Background and Supporting Information

High grade gliomas are primary central nervous system tumors defined by a World Health Organization (WHO) histologic grade of III or IV. These tumors arise from glial cells and may occur anywhere within the CNS, although the majority originate in the cerebral hemispheres. Entities in this category include anaplastic astrocytoma, glioblastoma multiforme, diffuse intrinsic pontine glioma (DIPG, or "brainstem glioma"), gliomatosis cerebri, gliosarcoma, anaplastic oligodendroglioma, anaplastic ganglioglioma, anaplastic mixed glioma, anaplastic mixed ganglioneuronal tumors, and any other glial tumor with a WHO grade of III or IV (Louis et al., 2021).

High grade gliomas are characterized by aggressive growth, infiltrative behavior, and a high propensity for recurrence despite multimodality therapy. Tumor-related mass effect, edema, and involvement of eloquent brain regions are common, and cerebrospinal fluid dissemination may occur, particularly in pediatric and midline tumors. Baseline and longitudinal imaging play a critical role in defining disease extent, treatment response, and progression (NCCN, 2026; NICE, 2021).

Evidence Discussion

Imaging strategies for high grade gliomas emphasize timely, comprehensive assessment while avoiding unnecessary testing or delays in care. MRI of the brain without and with contrast is the foundation of imaging evaluation, providing critical information regarding tumor extent, enhancement characteristics, and treatment-related change. Inclusion of whole-spine MRI at initial staging is supported by evidence that detection of spinal metastases or leptomeningeal disease alters prognosis and therapeutic strategy, particularly in aggressive or midline tumors (NCCN, 2026; NICE, 2021).

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Postoperative and post-radiation MRI establishes a new baseline for comparison and is essential for distinguishing residual tumor from postoperative change or early treatment effects. During active chemotherapy, interval MRI allows for assessment of disease response and early identification of progression or complications. Patients with documented spinal involvement benefit from concurrent imaging of the affected spinal region on the same schedule, supporting coordinated disease monitoring without unnecessary duplication (NCCN, 2026).

Advanced imaging modalities offer incremental diagnostic value but carry recognized limitations that warrant restricted use. MR perfusion imaging can estimate tumor vascularity and has demonstrated utility in differentiating recurrent tumor from radiation-induced necrosis. MR spectroscopy provides metabolic information that may assist in distinguishing high grade from lower grade lesions and in evaluating post-treatment changes. However, variability in technique and interpretation limits these tools to problem-solving roles when standard MRI is inconclusive or insufficient to guide management decisions (ACR, 2016; ACR, 2017; Mabray et al., 2015).

Metabolic brain PET imaging may help clarify indeterminate MRI findings or distinguish progression from treatment-related effects in select cases. Evidence does not support routine PET use across all high grade gliomas, and PET has limited utility in brainstem tumors such as DIPG due to poor tracer uptake and lack of demonstrated impact on outcomes. Restricting PET and other advanced modalities to defined clinical scenarios helps balance diagnostic benefit against radiation exposure, cost, and potential for misleading results (Kong et al., 2018; NICE, 2021).

Health Equity Considerations

High-grade gliomas (HGGs) are aggressive primary brain tumors associated with substantial morbidity and mortality, where timely diagnosis and accurate imaging assessment are critical to clinical decision-making. Emerging evidence demonstrates clinically meaningful sociodemographic disparities in the presentation of HGGs that have direct implications for imaging evaluation. In a multi-institutional retrospective analysis, Black and Hispanic patients were more likely to present with severe neurologic symptoms and radiographic features such as mass effect and midline shift, whereas White patients more frequently presented with subtler cognitive symptoms (Ghosh et al., 2025). These differences in clinical and imaging presentation may influence the urgency of diagnostic workup, patterns of initial neuroimaging utilization, and thresholds for advanced imaging, potentially contributing to downstream differences in treatment planning and outcomes.

Structural and sociodemographic barriers further compound equity challenges in the care of patients with HGGs. Prior studies have documented that patients from marginalized racial and socioeconomic backgrounds are more likely to experience delays in specialty referral, inconsistent follow-up imaging, and barriers related to

insurance coverage, transportation, and access to high-volume neuro-oncology centers (Perez et al., 2026). Given the central role of MRI in diagnosis, surgical planning, and longitudinal assessment of treatment response in HGG, inconsistent access to timely and guideline-concordant imaging risks exacerbating disparities in disease staging and outcome assessment. Standardized, evidence-based imaging recommendations for suspected and established HGGs promote health equity by supporting consistent evaluation frameworks across care settings, regardless of patient race, ethnicity, or socioeconomic status, and by facilitating more equitable access to appropriate oncologic management and longitudinal monitoring (Ghosh et al., 2025; Perez et al., 2026).

Oncology Imaging Guidelines

Medulloblastoma (MDB), Other CNS Embryonal Tumors, and Pineoblastoma (ONC-2.4)

ON.CN.0002.4.A
v1.0.2027

Criteria

- Includes the following tumors:
  - Medulloblastoma
    - Molecularly-defined Medulloblastoma
      - WNT-activated Medulloblastoma
      - SHH-activated and TP53-wildtype Medulloblastoma
      - SHH-activated and TP53-mutant Medulloblastoma
      - Non-WNT/Non-SHH
    - Medulloblastoma, histologically defined
  - Other CNS Embryonal Tumors (previously supratentorial primitive neuro-ectodermal tumors)
    - CNS embryonal tumor
    - Cribriform neuroepithelial tumor
    - Embryonal tumor with multilayered rosettes
    - CNS neuroblastoma
    - FOXR2-activated CNS tumor with BCOR internal tandem duplication
  - Pineoblastoma
- Risk assessment is important in determining optimal treatment. High-risk features include the following:
  - Spinal metastases (including cytology positive only)
  - Multifocal intracranial tumors
  - Anaplastic histology
  - All other CNS embryonal tumors and pineoblastomas
  - >1.5cm^2 residual tumor area on postoperative MRI and age less than 3 years
- Individuals without any high-risk features are considered "average risk"
- MR Spectroscopy and PET Brain Metabolic are not considered medically necessary for routine surveillance for individuals with MDB, other CNS embryonal tumors, and pineoblastoma.

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Indication	Medically Necessary Imaging Study
Initial staging for all individuals with MDB, other CNS embryonal tumors, and pineoblastoma, preoperatively	• MRI Brain without and with contrast (CPT® 70553) • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)
In addition to the above imaging, for initial staging for preoperative planning for individuals with MDB, other CNS embryonal tumors, and pineoblastoma	• Functional MRI (fMRI) (CPT® 70555 or 70554) • For further perioperative indications, please refer to **Neuronavigation (HD-28.2)**
• At any time, for ANY of the following for individuals with MDB, other CNS embryonal tumors, and pineoblastoma: ◦ For rapid assessment in the acute setting ◦ Evaluation of suspected acute intracranial hemorrhage ◦ Evaluation of ventriculomegaly ◦ Evaluation of shunt-related issues	• CT Head without contrast (CPT® 70450)
• ANY of the following for individuals with MDB, other CNS embryonal tumors, and pineoblastoma: ◦ To distinguish radiation-induced tumor necrosis from progressive disease within 18 months of completing radiotherapy ◦ To evaluate inconclusive MRI findings when the PET findings will be used to determine need for biopsy or change in therapy, including a change from active therapy to surveillance ◦ To evaluate a brain lesion of indeterminate nature when the PET findings will be used to determine whether biopsy/resection can be safely postponed	• PET Brain Metabolic Imaging (CPT® 78608)

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Indication	Medically Necessary Imaging Study
• For individuals with MDB, other CNS embryonal tumors, and pineoblastoma: ◦ To evaluate a brain lesion of indeterminate nature when the MRS findings will be used to determine whether biopsy/resection can be safely postponed	• MR Spectroscopy (CPT® 76390)
Postoperative (preferably within 48 hours of surgery) to quantify residual tumor volume for individuals with MDB, other CNS embryonal tumors, and pineoblastoma	• MRI Brain without and with contrast (CPT® 70553) • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) if spinal disease was resected
Within 28 days post-op, if spinal imaging was not performed preoperatively for individuals with MDB, other CNS embryonal tumors, and pineoblastoma	• MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)
Treatment response for individuals with MDB, other CNS embryonal tumors, and pineoblastoma	• At the start of adjuvant chemotherapy and every 2 cycles until therapy is completed: ◦ MRI Brain without and with contrast (CPT® 70553) ◦ MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)
End of treatment evaluation for individuals with MDB, other CNS embryonal tumors, and pineoblastoma	• MRI Brain without and with contrast (CPT® 70553) • MRI Spine with contrast (Cervical-CPT® 72142, Thoracic-CPT® 72147, Lumbar-CPT® 72149) or MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)

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Indication	Medically Necessary Imaging Study
Signs or symptoms of recurrence or progression in individuals with MDB, other CNS embryonal tumors, and pineoblastoma	• MRI Brain without and with contrast (CPT® 70553) • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)
Surveillance for individuals with MDB, other CNS embryonal tumors, and pineoblastoma	For low- or average-risk individuals: • Every 2 months for 2 years, then every 6 months for 10 years, then annually: ◦ MRI Brain without and with contrast (CPT® 70553) • Every 6 months for 2 years: ◦ MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) For high- or very high-risk individuals: • Every 2 months for 2 years, then every 6 months for 10 years, then annually: ◦ MRI Brain without and with contrast (CPT® 70553) • Every 3 months for 2 years, then every year for 3 years: ◦ MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) • For additional imaging guidelines for individuals in long-term follow-up after CNS tumor treatment that included radiation therapy, see: **Second Malignant Neoplasms (SMN) (PEDONC-19.3)**

Evidence Discussion

MRI of the brain and spine with and without contrast is the cornerstone of imaging for medulloblastoma, other CNS embryonal tumors, and pineoblastoma because of its superior sensitivity for detecting primary tumor extent, residual disease, and dissemination throughout the neuraxis. These tumors have a high propensity for cerebrospinal fluid (CSF) spread, making comprehensive neuraxis imaging essential for

accurate staging and subsequent treatment planning (NCCN, 2026). Early postoperative MRI, ideally within 48 hours, is critical for quantifying residual tumor volume, which is a key factor in risk stratification and influences decisions regarding adjuvant therapy intensity. The benefit of serial MRI during treatment and follow-up is the ability to detect early disease progression or recurrence; however, potential harms include repeated contrast exposure, need for sedation in pediatric patients, and variability in interpretation of post-treatment changes such as pseudoprogression.

Frequent MRI surveillance during and after therapy is supported by the aggressive biology and recurrence patterns of these tumors, particularly within the first 2 years after treatment when recurrence risk is highest. Regular imaging of both brain and spine allows for timely detection of local and metastatic progression, which can inform modifications in therapy or prompt surgical or radiation interventions (NCCN, 2026). In high-risk populations, including those with metastatic disease or residual tumor, more frequent spine imaging improves detection of drop metastases and facilitates earlier treatment. While this intensive imaging approach improves clinical outcomes through earlier detection, it also increases cumulative healthcare utilization and resource burden.

Advanced imaging modalities, including PET brain metabolic imaging and MR spectroscopy, are reserved for specific clinical scenarios where conventional MRI is inconclusive. These modalities provide metabolic and biochemical information that can help distinguish tumor recurrence from treatment-related effects such as radiation necrosis or pseudoprogression, particularly within the first 18 months after radiotherapy (NCCN, 2026). Amino acid PET tracers and MR spectroscopy have demonstrated high sensitivity and specificity in differentiating viable tumor from necrosis, contributing to improved diagnostic confidence and more appropriate clinical decision-making regarding biopsy or treatment escalation. However, limitations include limited availability, variability in interpretation, and the potential for false-positive or false-negative findings, particularly with FDG-PET due to high background uptake in normal brain tissue.

The selective use of CT head without contrast for acute indications, such as evaluation of hemorrhage, hydrocephalus, or shunt complications, balances the need for rapid assessment with the goal of minimizing radiation exposure. CT provides rapid, widely available imaging in emergent settings, complementing MRI when immediate information is required (NCCN, 2026). Overall, the imaging strategy outlined in the clinical criteria reflects a balance between maximizing diagnostic accuracy and minimizing potential harms, using MRI as the primary modality supported by targeted use of CT, PET, and MR spectroscopy to address specific clinical questions and optimize patient management.

Health Equity Considerations

Equitable access to diagnosis and treatment for medulloblastoma, other CNS embryonal tumors, and pineoblastoma is influenced by clinical risk, health system capacity, and

sociodemographic factors. These tumors require timely multimodal care, including surgery, radiation, and chemotherapy, delivered in specialized centers, and delays in diagnosis or incomplete staging may adversely affect outcomes (Ronsley et al., 2024). Population-based analyses suggest that treatment receipt and modality selection can vary based on nonclinical factors, including insurance status, income, and geographic location. Additional disparities in care delivery include lower likelihood of receiving standard multimodal therapy among patients who are uninsured, from lower education neighborhoods, or younger at diagnosis, with these gaps correlating with worse outcomes (Dressler et al., 2018).

Health equity considerations extend into survivorship and long term management. Survivors of pediatric embryonal CNS tumors are at high risk for neurocognitive and psychosocial sequelae, necessitating ongoing multidisciplinary follow up (Ronsley et al., 2024). However, access to recommended services such as neuropsychological evaluation is uneven, with lower utilization among patients who are Hispanic, live farther from treatment centers, or reside in communities with fewer healthcare resources (Peterson et al., 2025). Neighborhood level factors, including reduced access to health services and socioeconomic opportunity, further contribute to disparities in post treatment care and functional outcomes. Recognition of these multilevel influences, including geographic, socioeconomic, and global resource variability, is critical when assessing imaging utilization, surveillance strategies, and supportive care needs to ensure equitable management across pediatric patients with medulloblastoma, other CNS embryonal tumors, and pineoblastoma.

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Ependymal Tumors (Ependymoma) (ONC-2.5)

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Criteria

- PET Brain Metabolic imaging does not have a defined role in the evaluation of ependymal tumors and therefore considered not medically necessary.
- MR Spectroscopy is not considered medically necessary for routine surveillance of ependymal tumors.
- Individuals with ependymal tumors with a complete resection should be imaged according to surveillance guidelines.
- Individuals with ependymal tumors with incomplete resection or high-risk histology that receive adjuvant radiation therapy should be imaged according to surveillance guidelines after end of radiotherapy imaging.
- RELA-fusion supratentorial ependymoma did not portend worse overall survival outcomes in recent Clinical Oncology Group studies, and is not considered an indication for more frequent surveillance imaging.
- Includes the following tumors:
  - Ependymal tumors
    - Supratentorial ependymoma
    - ZFTA fusion-positive Supratentorial ependymoma
    - YAP1 fusion-positive Posterior fossa ependymoma
    - Posterior fossa ependymoma, group
    - PFA Posterior fossa ependymoma, group PFB

Indication	Medically Necessary Imaging Study
Initial staging for all individuals with ependymal tumors	• MRI Brain without and with contrast (CPT® 70553) • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)
In addition to the above imaging, for preoperative planning in individuals with ependymal tumors	• Functional MRI (fMRI) (CPT® 70555 or 70554) • For further perioperative indications, please refer to **Neuronavigation (HD-28.2)**

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Indication	Medically Necessary Imaging Study
Evaluation of a brain lesion of indeterminate nature when the MRS findings will be used to determine whether biopsy/resection can be safely postponed in individuals with ependymal tumors	• MR Spectroscopy (CPT® 76390)
Baseline imaging following resection in individuals with ependymal tumors	• MRI Brain without and with contrast (CPT® 70553) or MRI without and with contrast of involved spinal level(s) (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)
Completion of radiotherapy in individuals with ependymal tumors	• MRI Brain without and with contrast (CPT® 70553) or MRI without and with contrast of involved spinal level(s) (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)
Prior to radiotherapy in individuals with ependymal tumors	• MRI of all known sites of measurable disease
Treatment response to induction chemotherapy in individuals with ependymal tumors	Every 2 cycles: • MRI Brain without and with contrast (CPT® 70553) or MRI without and with contrast of involved spinal level(s) (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)
End of induction chemotherapy and again at end of all therapy in individuals with ependymal tumors	• MRI Brain without and with contrast (CPT® 70553) • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)
Prior to second-look surgery in individuals with ependymal tumors	• MRI of all known sites of measurable disease
Signs or symptoms of recurrence, progression, or neurologic emergency in individuals with ependymal tumors	• MRI Brain without and with contrast (CPT® 70553) • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158)

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Indication	Medically Necessary Imaging Study
Surveillance, primary intracranial ependymal tumor and NO history of spinal cord involvement	• MRI Brain without and with contrast (CPT® 70553) every 3 months for 1 year, then every 4 months for 1 year, then every 6 months for 10 years ◦ For additional imaging guidelines for individuals in long term follow up after CNS tumor treatment that included radiation therapy, see: **Second Malignant Neoplasms (SMN) (PEDONC-19.3)** • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) can be approved annually for 2 years
Surveillance, primary intracranial ependymal tumor AND metastatic cord involvement at diagnosis	• MRI Brain without and with contrast (CPT® 70553) every 3 months for 1 year, then every 4 months for 1 year, then every 6 months for 10 years ◦ For additional imaging guidelines for individuals in long term follow up after CNS tumor treatment that included radiation therapy, see: **Second Malignant Neoplasms (SMN) (PEDONC-19.3)** • MRI Spine without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) every 3 months for 1 year, then every 4 months for 1 year, then every 6 months for 10 years
Surveillance, primary intraspinal ependymal tumor and NO history of intracranial involvement	• MRI without and with contrast of the involved spinal level(s) (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) every 3 months for 1 year, then every 4 months for 1 year, then every 6 months for 10 years

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Indication	Medically Necessary Imaging Study
Surveillance, primary intraspinal ependymal tumor AND metastatic intracranial involvement at diagnosis	• MRI of the involved spinal level(s) without and with contrast (Cervical-CPT® 72156, Thoracic-CPT® 72157, Lumbar-CPT® 72158) every 3 months for 1 year, then every 4 months for 1 year, then every 6 months for 10 years • MRI Brain without and with contrast (CPT® 70553) every 3 months for 1 year, then every 4 months for 1 year, then every 6 months for 10 years

Evidence Discussion

MRI of the brain and spine without and with contrast is the primary imaging modality for ependymal tumors because it provides comprehensive evaluation of both the primary tumor and potential dissemination throughout the neuraxis. Ependymomas can involve intracranial and spinal compartments, and staging requires full assessment of the brain and spinal axis to detect metastatic spread and guide treatment planning (NCCN, 2026). The use of MRI for baseline staging, postoperative assessment, and evaluation following radiotherapy supports accurate risk stratification and ensures that residual disease or progression is identified in a timely manner. MRI's high soft tissue resolution allows precise delineation of tumor extent, which is essential for surgical planning and radiation targeting, though it may be limited in distinguishing treatment-related changes from tumor progression in some cases.

Serial MRI during treatment, including assessment every 2 cycles of chemotherapy and at completion of therapy, allows objective evaluation of treatment response and supports clinical decision-making regarding continuation or modification of therapy. Early postoperative imaging is particularly important because extent of resection is a major prognostic factor in ependymoma, and immediate assessment of residual disease informs the need for additional surgery or adjuvant therapy (NCCN, 2026). Similarly, imaging at completion of radiotherapy establishes a new baseline for subsequent surveillance. While frequent imaging improves detection of recurrence or progression, it may also increase cumulative contrast exposure and healthcare utilization, necessitating a balance between diagnostic benefit and resource use.

Surveillance imaging strategies are guided by recurrence patterns, which often occur locally but may also involve the neuraxis. Regular MRI of the primary site and, when appropriate, the entire neuraxis enables early identification of recurrence, particularly during the first few years following treatment when risk is highest (NCCN, 2026). Stratification of surveillance imaging based on initial disease extent (intracranial versus spinal and presence of metastases) ensures that imaging is appropriately focused while

avoiding unnecessary studies. This targeted approach improves clinical efficiency while maintaining sensitivity for detecting recurrent disease.

Advanced imaging modalities such as PET brain metabolic imaging and MR spectroscopy are not routinely required because conventional MRI provides sufficient anatomic information for most clinical scenarios. While these techniques may offer additional metabolic or biochemical data, their routine use is limited by variability in availability, interpretation, and incremental diagnostic value compared with MRI (NCCN, 2026). Restricting their use to selected problem-solving situations minimizes unnecessary imaging, reduces cost, and avoids potential false-positive findings. Overall, the imaging approach emphasizes MRI as the central modality, with structured timing across the disease continuum to optimize detection of residual disease, treatment response, and recurrence while minimizing unnecessary interventions.

Health Equity Considerations

Equitable diagnosis and management of ependymal tumors, including ependymoma, depend on timely access to specialized neurosurgical care, radiation therapy, and multidisciplinary oncology services. Optimal treatment, centered on maximal safe resection followed by radiation in most cases, requires access to high volume centers with pediatric and neuro oncology expertise, and disparities in these resources may influence outcomes (Coltin et al., 2024; Jagtiani et al., 2024). Population based analyses indicate that socioeconomic and insurance status are associated with differences in care delivery, including prolonged hospital stays among uninsured patients and reduced likelihood of optimal surgical management among lower income populations (Jagtiani et al., 2024). Additional disparities have been observed across racial and demographic groups, such as lower odds of resection among Black patients and differences in treatment utilization by age, which may reflect structural barriers, access to expertise, or referral patterns rather than biologic variation alone (Jagtiani et al., 2024). These findings underscore the importance of equitable referral pathways, access to specialized centers, and consistent application of evidence based treatment protocols.

Social determinants of health, including income, education, insurance status, and geographic location, also affect perioperative outcomes, treatment utilization, and healthcare utilization following diagnosis. Language barriers, cultural differences, and resource availability have been identified as contributors to delays or inequities in care delivery, particularly among Hispanic and underserved populations (Jagtiani et al., 2024). Although overall survival for ependymoma is relatively favorable compared to other CNS tumors, survival differences may still reflect disparities in access to complete resection, radiation therapy, and longitudinal care rather than differences in tumor biology alone (Coltin et al., 2024; Jagtiani et al., 2024). Addressing these barriers requires system level interventions to ensure equitable access to surgical expertise, radiation facilities, and supportive oncology services.

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Health equity considerations extend beyond initial treatment to survivorship, where long term morbidity is substantial and disproportionately impacts patients with limited access to ongoing care. Survivors of childhood ependymoma experience significantly higher risks of chronic health conditions, including stroke, hearing loss, hospitalization, disability, and need for homecare services compared to the general population (Coltin et al., 2024). These long term outcomes necessitate sustained access to multidisciplinary surveillance and rehabilitation services, which may be variably available across regions and populations. Socioeconomic factors, including neighborhood income and access to healthcare infrastructure, likely influence the ability to obtain these services and may contribute to disparities in functional outcomes and quality of life. Consideration of these multilevel factors, including access to specialized care, socioeconomic barriers, and long term support resources, is essential in the imaging, surveillance, and management of patients with ependymal tumors to promote equitable outcomes across diverse patient populations.

Oncology Imaging Guidelines

Central Nervous System Germ Cell Tumors (ONC-2.6)

ON.CN.0002.6.A

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- Central nervous system germ cell tumor imaging indications in adult individuals are identical to those for pediatric individuals. See: **CNS Germinomas and Non-Germinomatous Germ Cell Tumors (NGGCT) (PEDONC-4.7)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

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CNS Lymphoma (Also Known as Microglioma) (ONC-2.7)

ON.CN.0002.7.A
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Criteria

Indication	Medically Necessary Imaging Study
Initial staging of CNS lymphoma	ALL of the following: • MRI Brain without and with contrast (CPT® 70553) • MRI Cervical Spine without and with contrast (CPT® 72156) • MRI Thoracic Spine without and with contrast (CPT® 72157) • MRI Lumbar Spine without and with contrast (CPT® 72158)
Extra-neural evaluation to confirm CNS primary *Individuals with CNS Lymphoma that is metastatic should be imaged according to: • **Non-Hodgkin Lymphomas (ONC-27)** for individuals 19 years of age or older • **Pediatric Aggressive Mature B-Cell Non-Hodgkin Lymphomas (NHL) (PEDONC-5.3)** in the Pediatric Oncology Imaging Guidelines for individuals under the age of 19	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • PET/CT (CPT® 78815) for evaluation of inconclusive findings on CT imaging
Treatment response in individuals with CNS lymphoma	• MRI without and with contrast of all positive disease sites every 2 cycles

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Indication	Medically Necessary Imaging Study
Suspected intracranial or intraspinal recurrence in individuals with CNS lymphoma	• All imaging considered medically necessary for initial staging
Surveillance in individuals with CNS lymphoma	• For all individuals: MRI Brain (CPT® 70553) without and with contrast every 2-3 months for 2 years, then every 6 months to year 5, then annually thereafter • In individuals with a history of leptomeningeal disease, the following may be approved in addition to MRI Brain every 2-3 months for 2 years, then every 6 months to year 5, then annually thereafter: ◦ MRI Spine without and with contrast (CPT® 72156, 72157, and/or 72158)

Background and Supporting Information

Primary central nervous system lymphoma, historically referred to as microglioma, is a rare and aggressive form of non-Hodgkin lymphoma confined to the central nervous system, including the brain, spinal cord, cranial nerves, leptomeninges, cerebrospinal fluid, and eyes. The majority of cases represent diffuse large B cell lymphoma arising within immune privileged CNS compartments and occur in both immunocompetent and immunocompromised individuals (Grommes et al., 2018; Louis et al., 2021).

Primary central nervous system lymphoma accounts for approximately 4% of all intracranial malignancies and is characterized by a highly infiltrative growth pattern with a strong predilection for periventricular white matter, deep gray structures, and the corpus callosum. Unlike most primary brain tumors, PCNSL is highly sensitive to chemotherapy and radiation therapy, making accurate diagnosis and staging essential for optimal management (Grommes et al., 2018).

Evidence Discussion

Imaging recommendations for CNS lymphoma are designed to ensure complete assessment of disease extent while distinguishing primary CNS involvement from secondary systemic lymphoma. MRI of the brain without and with contrast is essential for identifying characteristic parenchymal lesions, defining disease burden, and guiding biopsy. Whole-spine MRI with contrast is justified at initial staging given the documented, though often clinically silent, potential for leptomeningeal and spinal

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involvement, which significantly impacts prognosis and treatment planning (Grommes et al., 2018; NCCN, 2026).

Confirmation that lymphoma is confined to the CNS requires extra-neural evaluation. CT of the chest, abdomen, and pelvis with contrast is supported by evidence demonstrating that a subset of patients initially suspected of having PCNSL are ultimately found to have systemic lymphoma with CNS involvement. FDG-PET/CT is reserved for cases with inconclusive CT findings, reflecting its limited incremental yield and the need to balance diagnostic benefit against radiation exposure (Grommes et al., 2018; NCCN, 2026).

Serial MRI assessment during treatment provides a noninvasive means to evaluate therapeutic response in a tumor that is highly chemosensitive yet prone to relapse. Imaging after every two cycles of therapy allows early identification of refractory disease or progression, facilitating timely modification of treatment strategies. Repeating all staging imaging in cases of suspected recurrence is supported by evidence that relapses are frequently multifocal and confined to the CNS compartment (Grommes et al., 2018).

Surveillance imaging intervals reflect the aggressive natural history of CNS lymphoma, with most relapses occurring within the first two years after diagnosis. MRI surveillance strategies stratified by prior parenchymal versus leptomeningeal involvement are supported by long-term outcome data demonstrating ongoing risk of recurrence even years after initial remission. Limiting surveillance to MRI of previously involved sites reduces unnecessary testing while maintaining sensitivity for clinically meaningful disease recurrence (Grommes et al., 2018; NCCN, 2026).

Health Equity Considerations

Primary central nervous system lymphoma is an aggressive and neurologically morbid malignancy for which timely diagnosis and accurate imaging assessment are central to treatment selection and outcome monitoring. Population-based analyses demonstrate that socioeconomic disadvantage is independently associated with worse overall and cancer-specific survival in primary central nervous system lymphoma, even after adjustment for clinical factors (Deng et al., 2022). Individuals residing in more deprived areas are less likely to receive standard-of-care therapies and more likely to have comorbid conditions, including HIV, that may complicate diagnostic evaluation and longitudinal imaging assessment (Deng et al., 2022). These disparities underscore the importance of consistent application of evidence-based imaging strategies to facilitate early diagnosis, accurate disease characterization, and timely initiation of appropriate therapy across diverse populations.

Health system–level factors further contribute to inequities in primary central nervous system lymphoma management and imaging utilization. Real-world data indicate that individuals treated in safety-net hospital settings, who are more often uninsured,

from racial and ethnic minority groups, or living with HIV, are less likely to receive intensive treatment regimens and experience differences in diagnostic and surveillance imaging pathways, reflecting resource constraints and access limitations (Patel et al., 2022). Given the reliance on MRI for diagnosis, treatment planning, and response assessment in primary central nervous system lymphoma, variability in access to guideline-concordant imaging may amplify existing disparities in care and outcomes. Awareness of these structural and socioeconomic factors is essential when implementing imaging guidelines, supporting more equitable diagnostic evaluation, disease monitoring, and treatment assessment across varied care settings (Deng et al., 2022; Patel et al., 2022).

Oncology Imaging Guidelines

Meningiomas (Intracranial and Intraspinal) (ONC-2.8)

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Criteria

Indication	Medically Necessary Imaging Study
Inconclusive MRI Brain or CT Head and further imaging is needed to confirm diagnosis of meningioma	• Dotatate PET/CT Brain (CPT® 78814)
Initial staging of intra**cranial** meningioma	ANY or ALL of the following: • MRI Brain without and with contrast (CPT® 70553) • CT Head (contrast as requested)
Initial staging of intra**spinal** meningioma	ONE of the following: • MRI without and with contrast of appropriate spinal region (Cervical CPT® 72156, Thoracic CPT® 72157, and Lumbar CPT® 72158) OR • CT without and with contrast of the appropriate spinal region (Cervical CPT® 72127, Thoracic CPT® 72130, and Lumbar CPT® 72133)
Treatment response in individuals with meningioma	Every 2 cycles: • MRI Brain without and with contrast (CPT® 70553) • MRI without and with contrast of appropriate spinal region (Cervical CPT® 72156, Thoracic CPT® 72157, and Lumbar CPT® 72158) • MRI without and with contrast of all otherpositive disease sites

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Indication	Medically Necessary Imaging Study
Suspected recurrence of intracranial or intraspinal disease	ANY or ALL of the following: • MRI Brain without and with contrast (CPT® 70553) • CT Head (contrast as requested) AND ONE of the following: • MRI without and with contrast of appropriate spinal region (Cervical CPT® 72156, Thoracic CPT® 72157, and Lumbar CPT® 72158) OR • CT without and with contrast of the appropriate spinal region (Cervical CPT® 72127, Thoracic CPT® 72130, and Lumbar CPT® 72133)
Suspected recurrence of meningioma with inconclusive findings on MRI	Any ONE of the following studies: • Octreotide SPECT Brain (CPT® 78803) • Octreotide SPECT/CT Brain (CPT® 78830) • Dotatate PET/CT Brain (CPT® 78814) • PET/MRI Brain (CPT® 78811 and 76498)
Post-operatively for resected or partially resected intra**cranial** meningiomas irrespective of grade	In addition to the imaging listed below: • MRI Brain without and with contrast (CPT® 70553) at 24-48 hours after surgical intervention
Surveillance for Grade I (low-grade), completely resected intra**cranial** meningiomas	Annual MRI Brain without and with contrast (CPT® 70553) followed by discontinuation of surveillance if there is no recurrence after 11 years
Surveillance for Grade I (low-grade), or unspecified Grade intra**cranial** meningioma (partially resected and unresected)	• MRI Brain without and with contrast (CPT® 70553) at 1, 3, and 6 months, then every 6 months for 5 years, then annually up to 11 years
Surveillance for Grade II (atypical), completely resected intra**cranial** meningiomas	MRI Brain without and with contrast (CPT® 70553) annually indefinitely
Surveillance for Grade II (atypical) intra**cranial** meningioma (partially resected and unresected)	• MRI Brain without and with contrast (CPT® 70553) at 1, 3, and 6 months, then every 6 months for 5 years, then annually indefinitely

Indication	Medically Necessary Imaging Study
Surveillance for Grade III (malignant or anaplastic) intra**cranial** meningioma	MRI Brain without and with contrast (CPT® 70553) every 2 months for 3 years, and then every 3 months indefinitely
Surveillance for Grade I (low-grade), completely resected intra**spinal** meningiomas	MRI of the involved spinal level without and with contrast [ANY of the following: (CPT® 72156 [Cervical spine], CPT® 72157 [Thoracic spine], CPT® 72158 [Lumbar spine])] or CT of the involved spinal level without and with contrast [ANY of the following: (CPT® 72127 [Cervical spine], CPT® 72130 [Thoracic spine], CPT® 72133 [Lumbar spine])] annually followed by discontinuation of surveillance if there is no recurrence after 11 years
Surveillance for Grade II (atypical), completely resected intra**spinal** meningiomas	MRI of the involved spinal level without and with contrast [ANY of the following: (CPT® 72156 [Cervical spine], CPT® 72157 [Thoracic spine], CPT® 72158 [Lumbar spine])] or CT of the involved spinal level without and with contrast [ANY of the following: (CPT® 72127 [Cervical spine], CPT® 72130 [Thoracic spine], CPT® 72133 [Lumbar spine])] annually indefinitely
Surveillance for Grade I (low-grade), and Grade II (atypical) or unspecified Grade intra**spinal** meningioma (partially resected and unresected)	ONE of the following at 3, 6, and 12 months, and then every 6 months for 5 years, then 1-3 years thereafter as requested: • MRI without and with contrast (CPT® 72156 [Cervical spine], CPT® 72157 [Thoracic spine], CPT® 72158 [Lumbar spine]) of the involved spinal level OR • CT without and with contrast (CPT® 72127 [Cervical spine], CPT® 72130 [Thoracic spine], CPT® 72133 [Lumbar spine]) of the involved spinal level

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Indication	Medically Necessary Imaging Study
Surveillance for Grade III (malignant or anaplastic) intra**spinal** meningioma	MRI of the involved spinal level without and with contrast [ANY of the following: (CPT® 72156 [Cervical spine], CPT® 72157 [Thoracic spine], CPT® 72158 [Lumbar spine])] or CT of the involved spinal level without and with contrast [ANY of the following: (CPT® 72127 [Cervical spine], CPT® 72130 [Thoracic spine], CPT® 72133 [Lumbar spine])] every 3-4 months for 2 years, and then every 6 months indefinitely

Background and Supporting Information

Meningiomas are the most common primary tumors of the central nervous system, accounting for approximately one third of all primary intracranial and intraspinal neoplasms. These tumors are extra axial and arise from arachnoid cap cells of the meninges, occurring throughout the neuroaxis, including the cranial and spinal compartments. Meningiomas are classified by the World Health Organization (WHO) into three histologic grades, Grade I (benign), Grade II (atypical), and Grade III (anaplastic or malignant), which correlate with risks of recurrence and aggressive behavior (Maas et al., 2021; NCCN, 2026).

Evidence Discussion

Imaging recommendations for meningiomas aim to balance comprehensive disease assessment with avoidance of unnecessary imaging burden. MRI without and with contrast is the cornerstone of diagnosis and follow-up, providing high sensitivity for soft-tissue characterization and detection of residual or recurrent disease. CT imaging is justified in selected cases due to the frequent involvement of adjacent bone, where CT offers superior depiction of hyperostosis and osseous infiltration that may influence surgical planning and response assessment (NCCN, 2026).

Meningiomas demonstrate high expression of somatostatin receptor subtype 2, providing a biologic basis for functional imaging with radiolabeled somatostatin analogs. Techniques such as ^{68}Ga-DOTATATE PET/CT and octreotide-based SPECT imaging have emerged as useful adjuncts for problem-solving in cases with inconclusive conventional imaging or suspected recurrence, particularly in complex postoperative or post-radiation settings. Restricting these modalities to scenarios with diagnostic uncertainty limits unnecessary radiation exposure and avoids downstream overdiagnosis while preserving their high specificity for meningioma tissue (Galldiks et al., 2017; Huntoon et al., 2020).

Surveillance imaging intervals are guided by tumor grade, anatomic site, and extent of resection due to the variable natural history of meningiomas. Low-grade tumors demonstrate relatively slow growth but maintain long-term recurrence risk, supporting prolonged but gradually spaced surveillance. In contrast, Grade II and III meningiomas carry substantially higher recurrence rates, including late recurrence after complete resection, justifying more frequent and often indefinite imaging follow-up to enable early detection of progression (Maas et al., 2021; NCCN, 2026).

Emerging molecular risk stratification highlights that histologic grade alone does not fully capture recurrence risk, particularly for Grade I and II tumors. Integrated molecular-morphologic models provide improved prognostic discrimination and support individualized follow-up strategies. However, imaging surveillance remains the primary noninvasive method for monitoring disease behavior, and adherence to structured imaging intervals ensures timely identification of clinically meaningful recurrence while minimizing cumulative imaging harms (Maas et al., 2021).

Health Equity Considerations

Meningiomas demonstrate well-documented variation in incidence, clinical presentation, and outcomes across racial, ethnic, and socioeconomic groups, with important implications for diagnostic imaging. Population-based and institutional studies consistently show higher incidence rates among Black individuals, who are also more likely to present with symptomatic disease, peritumoral edema, and diagnoses made through emergent care settings rather than planned outpatient evaluation (Jackson et al., 2022; Li et al., 2025; Pugazenthi et al., 2024). Lower socioeconomic status at the individual or county level has been associated with delayed diagnosis and more advanced clinical or radiographic presentation, suggesting inequities in access to routine care and early neuroimaging (Jackson et al., 2022; Pugazenthi et al., 2024). These differences may influence the urgency, modality, and extent of imaging evaluation, including the need for advanced MRI techniques to accurately assess tumor burden, mass effect, and involvement of adjacent structures.

Access-related and structural factors further contribute to disparities in imaging utilization and longitudinal surveillance for individuals with meningiomas. Evidence indicates that patients from lower socioeconomic backgrounds and those who are publicly insured or reside in resource-limited settings are less likely to receive timely specialty referral and consistent follow-up imaging, which may delay detection of tumor growth, progression, or recurrence (Lei et al., 2023; Pugazenthi et al., 2024). Systematic reviews and epidemiologic analyses suggest that these disparities persist even after accounting for tumor characteristics and treatment factors, highlighting the role of health system-level barriers in care delivery (Lei et al., 2023; Li et al., 2025). Consistent application of evidence-based imaging criteria is therefore essential to support equitable diagnosis, monitoring, and treatment planning for both intracranial and intraspinal meningiomas, particularly for populations at increased risk of delayed presentation,

fragmented surveillance, or under-assessment of disease progression (Jackson et al., 2022; Lei et al., 2023).

Oncology Imaging Guidelines

Spinal Cord Tumors (Benign and Malignant) (ONC-2.9)

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- See: **Low Grade Gliomas (ONC-2.2)** and **High Grade Gliomas (ONC-2.3)** for imaging guidelines of low-grade and high-grade gliomas of the spinal cord
- See: **Malignant Tumors of the Spinal Cord (PEDONC-4.9)** in the Pediatric and Special Populations Oncology Imaging Guidelines for other malignant spinal cord tumors
- See: in the Pediatric and Special Populations Oncology Imaging Guidelines for spinal tumors in individuals with Neurofibromatosis 1 or 2
- See: **Spinal/Vertebral Metastases (ONC-31.6)** for known secondary malignancy involving the spine/spinal canal/spinal cord

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Choroid Plexus Tumors (ONC-2.10)

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- Choroid Plexus Tumor imaging indications in adult individuals are identical to those for pediatric individuals. See: **Choroid Plexus Tumors (PEDONC-4.13)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

Oncology Imaging Guidelines

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Squamous Cell Carcinomas, Esthesioneuroblastoma, and Undifferentiated Carcinomas of the Head and Neck (ONC-3)

Guideline Page

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Squamous Cell Carcinomas, Esthesioneuroblastoma, and Undifferentiated Carcinomas of the Head and Neck – General Considerations (ONC-3.0)

ON.HN.0003.0.A
v1.0.2027

Criteria

- Individuals with esthesioneuroblastoma should be imaged according to this guideline section.

Background and Supporting Information

Squamous cell carcinomas of the head and neck (HNSCC) arise from the mucosal epithelium of the upper aerodigestive tract, including the oral cavity, oropharynx, hypopharynx, larynx, nasopharynx, and sinonasal cavities. Histologically distinct tumors such as esthesioneuroblastoma share anatomic overlap and patterns of local extension and nodal spread and are therefore evaluated using the same general imaging framework. Accurate anatomic delineation of primary tumor extent and regional nodal involvement is essential for clinical staging and treatment planning (NCCN, 2026).

Clinical staging of HNSCC incorporates tumor size, depth of invasion, anatomic spread, and regional lymph node involvement. Stage III and IV disease encompasses tumors larger than 4cm and/or those with documented regional lymph node metastases, reflecting a higher risk of locoregional failure and distant spread. These stages are associated with increased likelihood of multimodality therapy and a greater need for comprehensive baseline imaging (NCCN, 2026).

Health Equity Considerations

Squamous cell carcinomas of the head and neck (HNSCC) demonstrate substantial and well-documented disparities in stage at diagnosis, tumor biology, and clinical outcomes across racial, socioeconomic, and geographic populations. Lower socioeconomic status, lack of insurance coverage, and rural residence are consistently associated with delayed diagnosis and more advanced disease at presentation, increasing the likelihood that initial imaging occurs in urgent or emergent settings rather than through timely, planned diagnostic evaluation (Marrero-Gonzalez & Graboyes, 2024; Baliga et al., 2023). Black patients are disproportionately affected by advanced-stage and HPV-negative disease and experience longer diagnostic and treatment intervals compared with White patients,

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factors that may influence staging completeness, selection of initial imaging modalities, and overall care trajectories (Baliga et al., 2023; Lin et al., 2024). These disparities highlight the importance of standardized imaging approaches to support accurate staging and equitable care delivery at the point of diagnosis.

Structural barriers to specialty care further contribute to inequities in imaging utilization and longitudinal surveillance among patients with HNSCC. Neighborhood-level socioeconomic disadvantage has been associated with worse survival outcomes and lower likelihood of receiving timely, guideline-concordant diagnostic imaging and post-treatment surveillance, including cross-sectional imaging and PET/CT for nodal assessment and response evaluation (Benjamin et al., 2025; Marrero-Gonzalez & Graboyes, 2024). Differences in access to high-volume centers and multidisciplinary care may further exacerbate variation in imaging follow-up and recurrence detection across populations (Lin et al., 2024). Consistent application of evidence-based imaging criteria, including appropriate use of CT, MRI, and PET/CT for staging and surveillance, supports health equity by promoting diagnostic accuracy and longitudinal disease monitoring regardless of race, socioeconomic status, or geographic location (Benjamin et al., 2025; Marrero-Gonzalez & Graboyes, 2024).

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Squamous Cell Carcinomas, Esthesioneuroblastoma, and Undifferentiated Carcinomas of the Head and Neck – Suspected/Diagnosis (ONC-3.1)

ON.HN.0003.1.A
v1.0.2027

Criteria

- See: **Neck Masses - Imaging (NECK-5.1)** in the Neck Imaging Guidelines for evaluation of suspected malignancy in the neck.
- PET is considered medically necessary prior to biopsy in individuals with suspected squamous cell carcinomas of the head and neck in order to determine a more favorable site for biopsy when:
  - a prior biopsy was nondiagnostic or
  - a relatively inaccessible site is contemplated which would require invasive surgical intervention for biopsy attempt

Background and Supporting Information

Squamous cell carcinomas of the head and neck (HNSCC) arise from the mucosal epithelium of the upper aerodigestive tract and frequently present with nonspecific symptoms such as persistent neck mass, mucosal lesion, dysphagia, hoarseness, or unexplained pain. At initial presentation, the primary tumor may be occult, and cervical lymphadenopathy is often the first or only clinical finding. Accurate imaging evaluation is therefore central to identifying the primary site, defining disease extent, and guiding diagnostic procedures (NCCN, 2026).

Evidence Discussion

The diagnostic imaging approach for suspected HNSCC is supported by evidence demonstrating that early and accurate anatomic assessment improves identification of the primary tumor and regional nodal disease. Evidence supports the use of PET prior to biopsy in cases of nondiagnostic prior biopsy or when biopsy would otherwise require extensive surgical intervention. By identifying the most metabolically active site, PET imaging increases the likelihood of diagnostic success and reduces the need for repeated invasive procedures, thereby limiting patient risk (NCCN, 2026).

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Limiting PET use to these specific situations avoids unnecessary radiation exposure and false positive findings that may complicate diagnosis. Routine use of PET prior to biopsy in all suspected HNSCC cases has not demonstrated additional benefit and may increase downstream testing. Targeted application of PET aligns diagnostic benefit with patient safety and evidence based resource utilization (NCCN, 2026).

Overall, the clinical imaging criteria for suspected HNSCC reflect a balance between thorough diagnostic evaluation and avoidance of procedural harm. Imaging guided biopsy planning improves diagnostic efficiency, reduces morbidity associated with repeat or extensive surgical biopsies, and supports timely initiation of appropriate therapy once a histologic diagnosis is established (NCCN, 2026).

Oncology Imaging Guidelines

Squamous Cell Carcinomas, Esthesioneuroblastoma, and Undifferentiated Carcinomas of the Head and Neck – Initial Work-up/Staging (ONC-3.2)

ON.HN.0003.2.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All stages of disease in individuals with squamous cell carcinomas of the head and neck	• CT Neck with contrast (CPT® 70491) **or** MRI Orbits/Face/Neck (OFN) without and with contrast (CPT® 70543) • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250)
For sentinel lymph node evaluation when nodes are not clinically positive in individuals with squamous cell carcinomas of the head and neck	• Lymph system imaging (lymphoscintigraphy, CPT® 78195) ◦ SPECT/CT (CPT® 78830) if requested
Nasal cavity and paranasal sinuses (bony erosion or skull base and intracranial involvement) in individuals with squamous cell carcinomas of the head and neck	ONE of the following: • CT Maxillofacial with contrast (CPT® 70487) • CT Neck with contrast (CPT® 70491) • MRI Orbits/Face/Neck without and with contrast (CPT® 70543)
Nasopharyngeal Cancer (NPC)	• PET/CT (CPT® 78815) • MRI Orbits/Face/Neck without and with contrast (CPT® 70543) is the preferred study ◦ CT Neck (CPT® 70491) **and/or** CT Maxillofacial (CPT® 70487) with contrast if contraindication to MRI • CT Chest with contrast (CPT® 71260)

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Indication	Medically Necessary Imaging Study
For ANY of the following in individuals with squamous cell carcinomas of the head and neck: • Known stage III or IV disease • To determine role for upfront surgery vs chemoradiation in T3-T4 size tumor • Prior to start of primary chemoradiotherapy and have not undergone definitive surgical resection • Inconclusive findings on conventional imaging (CT, MRI) • In order to direct laryngoscopy/exam under anesthesia for biopsy • Pulmonary nodule(s) ≥8mm in size • Cervical lymph node biopsy positive for squamous cell carcinoma and no primary site identified on CT or MRI Neck and Chest	• PET/CT (CPT® 78815)
Signs or symptoms of abdominal metastatic disease including, but not limited to, elevated liver function tests in individuals with squamous cell carcinomas of the head and neck	• CT Abdomen with contrast (CPT® 74160)
Any head and neck cancer with neurological findings or suspicion of skull base invasion	• MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Squamous cell carcinomas of the head and neck (HNSCC) originate from the mucosal surfaces of the upper aerodigestive tract and encompass tumors of the oral cavity, pharynx, larynx, nasopharynx, and sinonasal spaces. Initial clinical staging is based on tumor size and extent, regional nodal involvement, and the presence or absence of distant metastatic disease. Accurate determination of disease stage at presentation is essential for prognostication and selection of appropriate local, regional, and systemic treatment strategies (NCCN, 2026).

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Evidence Discussion

Accurate initial staging imaging is supported by evidence demonstrating improved treatment planning and avoidance of inappropriate or ineffective therapies. Contrast-enhanced CT or MRI of the neck provides essential anatomic detail for defining tumor extent and nodal disease, which directly impacts surgical resectability, the need for neck dissection, and radiation target volumes. Reliance on high-quality anatomic imaging minimizes understaging and reduces the risk of locoregional failure (Gule-Monroe et al., 2017; NCCN, 2026).

Evaluation for distant metastatic disease is guided by tumor stage, clinical features, and subsite-specific risk. Chest imaging identifies pulmonary metastases and second primary lung cancers, which occur in a meaningful proportion of patients at diagnosis and substantially alter management. Limiting abdominal imaging to individuals with suggestive clinical findings reflects the low prevalence of abdominal metastases and reduces unnecessary radiation exposure and false-positive findings (Awan et al., 2017; NCCN, 2026).

FDG-PET/CT improves detection of occult nodal disease and distant metastases in patients with stage III or IV disease and in those with equivocal findings on CT or MRI. Evidence supports PET/CT for identifying metabolically active disease that may not be apparent on anatomic imaging alone and for localizing primary tumor sites in cases of cervical nodal metastases with no identifiable primary on conventional studies. However, PET lacks sufficient anatomic resolution for accurate local "T" staging and is therefore used as an adjunct rather than a stand-alone modality (Moeller et al., 2009; Lowe et al., 2019; NCCN, 2026).

Restricting advanced imaging to defined clinical scenarios balances diagnostic benefit against potential harms, including radiation exposure, incidental findings, and unnecessary downstream procedures. Large observational studies demonstrate that indiscriminate imaging does not improve outcomes and may increase morbidity from false-positive results. The initial staging approach outlined in the clinical criteria aligns imaging intensity with disease risk, supporting high diagnostic yield while minimizing avoidable patient harm (Chen et al., 2023; Heineman et al., 2017; NCCN, 2026).

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Squamous Cell Carcinomas, Esthesioneuroblastoma, and Undifferentiated Carcinomas of the Head and Neck – Restaging/Recurrence (ONC-3.3)

ON.HN.0003.3.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Following primary chemoradiotherapy or radiation therapy or resection or any combination of these modalities in individuals with squamous cell carcinomas of the head and neck	ONE of the following: • CT Neck with contrast (CPT® 70491); **or** • MRI Orbits/Face/Neck without and with contrast (CPT® 70543); **or** • PET/CT (CPT® 78815) no sooner than 12 weeks (3 months) post completion of radiation therapy ◦ If post-treatment PET/CT scan is negative, further surveillance imaging is not considered medically necessary
Post-treatment PET is positive for residual disease in individuals with squamous cell carcinomas of the head and neck	ONE of the following: • CT Neck with contrast (CPT® 70491); **or** • MRI Orbits/Face/Neck without and with contrast (CPT® 70543)
Post-treatment PET is equivocal for residual disease in individuals with squamous cell carcinomas of the head and neck	PET/CT (CPT® 78815) 3-6 months from prior post-treatment PET/CT
Induction chemotherapy response in individuals with squamous cell carcinomas of the head and neck	• CT Neck with contrast (CPT® 70491) or MRI Orbits/Face/Neck without and with contrast (CPT® 70543) • PET is not considered medically necessary to assess response to induction chemotherapy

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Indication	Medically Necessary Imaging Study
Concern for progression seen on imaging performed at completion of induction chemotherapy in individuals with squamous cell carcinomas of the head and neck	EITHER or ALL of the following: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • PET/CT (CPT® 78815)
Measurable or metastatic disease undergoing active treatment in individuals with squamous cell carcinomas of the head and neck	Every 2 cycles (6-8 weeks): • CT Neck with contrast (CPT® 70491) OR • MRI Orbits/ Face/Neck without and with contrast (CPT® 70543) AND • CT with contrast of involved body sites
Suspected local recurrence in individuals with squamous cell carcinomas of the head and neck	• CT Neck with contrast (CPT® 70491) or MRI Orbits/ Face/Neck without and with contrast (CPT® 70543) • CT Chest with contrast (CPT® 71260)
Biopsy proven local recurrence in individuals with squamous cell carcinomas of the head and neck	ONE of the following: • PET/CT (CPT® 78815) **or** • CT Neck with contrast (CPT® 70491) or MRI Orbits/ Face/Neck without and with contrast (CPT® 70543) and CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250)
Inconclusive conventional imaging (CT or MRI) in individuals with squamous cell carcinomas of the head and neck	• PET/CT (CPT® 78815)

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Indication	Medically Necessary Imaging Study
If suspected non-response while on treatment in individuals with squamous cell carcinomas of the head and neck	• An additional CT Neck with contrast (CPT 70491) or MRI Orbits/Face/Neck without and with contrast (CPT 70543)
Any of the following in individuals with squamous cell carcinomas of the head and neck: • Known prior thoracic disease • New or worsening pulmonary symptoms • New or worsening chest x-ray findings	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250)

Background and Supporting Information

Restaging and evaluation for recurrence in squamous cell carcinomas of the head and neck (HNSCC) are integral components of post treatment management. Following surgery, radiation therapy, chemoradiotherapy, or combinations of these modalities, imaging is used to assess response to therapy, establish a new post treatment baseline, and identify residual or recurrent disease. Interpretation of post treatment imaging requires careful attention to expected anatomic and inflammatory changes related to therapy (NCCN, 2026).

Patterns of failure in HNSCC include local recurrence at the primary tumor site, regional cervical nodal recurrence, and distant metastases, most commonly involving the lungs and mediastinum. The risk of recurrence is highest within the first two to three years after treatment completion, particularly in individuals with advanced stage disease, extranodal extension, or incomplete response to therapy. Imaging strategies therefore emphasize early post treatment assessment followed by symptom directed evaluation thereafter (NCCN, 2026; Awan et al., 2017).

Evidence Discussion

Follow-up imaging after definitive treatment for HNSCC is supported by evidence demonstrating its value in evaluating treatment response and guiding subsequent management. In individuals treated with primary chemoradiotherapy without surgical resection, FDG-PET/CT performed no earlier than 12 weeks after completion of

radiation provides high diagnostic accuracy for residual disease. Studies show that a negative PET/CT at the 3–6-month interval is associated with a negative predictive value of approximately 95%–97% for locoregional recurrence, supporting discontinuation of routine surveillance imaging in asymptomatic individuals with negative findings (Moeller et al., 2009; Lowe et al., 2019; NCCN, 2026).

PET/CT performed earlier than this interval is associated with a high false-positive rate due to post-treatment inflammation and tissue remodeling, leading to unnecessary biopsies and interventions. For this reason, contrast-enhanced CT or MRI may be used as alternatives when PET is contraindicated, though these modalities generally add limited incremental value when a properly timed PET/CT is negative. Restricting PET use to optimal timeframes balances diagnostic benefit against the harms of false-positive findings and excess radiation exposure (NCCN, 2026; Marcus et al., 2025).

During induction chemotherapy and active treatment for measurable or metastatic disease, serial cross-sectional imaging every two cycles is supported to assess response and detect progression. PET is not routinely recommended for response assessment during induction chemotherapy because anatomic imaging provides sufficient information to guide treatment decisions, and metabolic changes may be difficult to interpret in the setting of ongoing therapy (Gule-Monroe et al., 2017; NCCN, 2026).

For suspected recurrence, CT or MRI of the primary site and CT of the chest are supported due to the frequency of asymptomatic pulmonary and mediastinal metastases at relapse. PET/CT is reserved for cases with biopsy-proven recurrence or inconclusive conventional imaging, as inflammatory changes following treatment contribute to reduced specificity. This stepwise approach maximizes diagnostic accuracy while minimizing unnecessary imaging, invasive procedures, and downstream harm (Awan et al., 2017; Chen et al., 2023; Heineman et al., 2017).

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Squamous Cell Carcinomas, Esthesioneuroblastoma, and Undifferentiated Carcinomas of the Head and Neck – Surveillance/Follow-up (ONC-3.4)

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Criteria

Indications	Medically Necessary Imaging Study
If post-resection (with or without post-operative radiation therapy) CT or MRI imaging shows residual abnormalities in individuals with squamous cell carcinomas of the head and neck	ONE of the following, once within 6 months of prior imaging: • CT Neck with contrast (CPT® 70491) OR • MRI Orbits/Face/Neck without and with contrast (CPT® 70543)
Individuals with squamous cell carcinomas of the head and neck treated with definitive radiotherapy	• A second PET/CT (CPT® 78815) is considered medically necessary at least 6 months after completion of therapy (i.e., 3 months from the prior PET)
Individuals with squamous cell carcinomas of the head and neck treated with definitive radiation therapy or combined chemoradiation, and 6-month PET imaging is negative	Further surveillance imaging is not routinely considered medically necessary

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Indications	Medically Necessary Imaging Study
After initial post-treatment study, for ANY of the following in individuals with squamous cell carcinomas of the head and neck: • Nasopharyngeal primary site • Difficult physical exam due to the effects of treatment (e.g., scarring, etc.) or unable to visualize deep-seated primary site	Annually for 3 years: • CT Neck with contrast (CPT® 70491) **or** MRI Orbits/Face/Neck without and with contrast (CPT® 70543)
• CT Chest is not considered medically necessary for surveillance. Individuals with squamous cell carcinomas of the head and neck with a smoking history may undergo annual low dose CT cancer screening if criteria are met (See: **Lung Cancer Screening (CH-33)** in the Chest Imaging Guidelines)	

Background and Supporting Information

Surveillance following definitive treatment of squamous cell carcinomas of the head and neck (HNSCC) is intended to detect clinically significant recurrence while minimizing unnecessary imaging and associated harms. After completion of surgery, radiation therapy, chemoradiation, or combined modalities, most individuals undergo an initial post-treatment imaging assessment to establish a baseline against which future changes can be compared. Subsequent imaging decisions are guided by clinical findings, tumor subsite, and the ability to adequately assess the primary site on physical examination (NCCN, 2026).

The majority of recurrences in HNSCC occur within the first three years after treatment, with the highest risk in the initial 6–12 months. Local and regional failures predominate, although distant metastases can occur, particularly in individuals with advanced initial stage disease or aggressive tumor biology. Surveillance strategies therefore emphasize early post treatment assessment followed by selective, problem focused imaging rather than routine long term scanning in asymptomatic individuals (Awan et al., 2017; NCCN, 2026).

Evidence Discussion

Evidence supporting surveillance imaging in HNSCC demonstrates greatest benefit in the early post-treatment period, when detection of residual or early recurrent disease may influence salvage therapy and prognosis. FDG-PET/CT performed 3–6 months after completion of definitive radiotherapy or chemoradiation has been shown to have a very high negative predictive value, allowing clinicians to safely discontinue routine

imaging in asymptomatic individuals with negative results. Performing additional imaging earlier than this window increases false-positive findings due to post-treatment inflammation and does not improve outcomes (Moeller et al., 2009; Lowe et al., 2019; NCCN, 2026).

There is no high-quality prospective evidence demonstrating a survival advantage for long-term routine surveillance imaging compared with careful clinical follow-up alone. Observational data show similar disease-free survival between individuals undergoing scheduled imaging surveillance and those followed primarily with clinical examination, supporting a limited and selective imaging strategy after initial post-treatment assessment (Heineman et al., 2017; Chen et al., 2023).

Selective use of CT or MRI within six months of prior imaging is supported when residual abnormalities are present on post-resection imaging, as progressive or resolving changes may alter management. Additionally, individuals with nasopharyngeal primary tumors or those with anatomic limitations to physical examination benefit from periodic cross-sectional imaging during the first three years, when the vast majority of recurrences occur (Awan et al., 2017; NCCN, 2026).

Routine CT chest imaging for surveillance of distant metastases is not supported due to low yield and lack of demonstrated outcome benefit. Lung metastases and second primary lung cancers are more effectively addressed through symptom-driven evaluation or established lung cancer screening pathways in individuals who meet smoking-related risk criteria. Limiting imaging to scenarios with proven benefit aligns surveillance practice with evidence-based risk–benefit considerations and reduces cumulative patient harm (Gule-Monroe et al., 2017; Chen et al., 2023).

Oncology Imaging Guidelines

References (ONC-3)

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Oncology Imaging Guidelines

Salivary Gland Cancers (ONC-4)

Guideline Page

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Salivary Gland Cancers – Suspected/ Diagnosis (ONC-4.1)

ON.SG.0004.1.A
v1.0.2027

Criteria

- See: **Salivary Gland Disorders (NECK-11)** and **Neck Masses – Imaging (NECK-5.1)** in the Neck Imaging Guidelines for evaluation of salivary gland masses, salivary gland stones, and neck masses.

Background and Supporting Information

Salivary gland cancers are rare, morphologically and clinically diverse malignancies arising from the major salivary glands (parotid, submandibular, sublingual) or from numerous minor salivary glands distributed throughout the oral cavity and upper aerodigestive tract. The parotid gland is the most common site of origin, accounting for approximately 70–80% of salivary gland neoplasms, the majority of which are benign. In contrast, tumors arising in the sublingual gland and many minor salivary gland sites have a substantially higher likelihood of malignancy. Overall, malignant salivary gland tumors account for less than 1% of all malignancies and approximately 3–5% of head and neck cancers (NCI, 2024).

Salivary gland carcinomas encompass a wide range of histologic subtypes, including mucoepidermoid carcinoma, acinic cell carcinoma, adenocarcinoma, adenoid cystic carcinoma, malignant myoepithelial tumors, and salivary duct carcinoma, among others. Squamous cell carcinoma and lymphoma may occur in the parotid gland, most often representing metastatic or secondary disease rather than primary salivary gland origin. Histologic grade, tumor size, site of origin, and extent of local or regional spread all contribute to prognosis, with clinical stage, particularly tumor size and extranodal extension, being a key determinant of outcome (NCI, 2024).

Although most parotid gland tumors are benign, bilateral parotid masses are most commonly Warthin tumors. Malignant disease should be suspected when imaging or clinical features demonstrate pain, rapid growth, facial nerve dysfunction, fixation to surrounding tissues, or regional lymphadenopathy. Given the rarity and heterogeneity of these tumors, management strategies are guided by multidisciplinary consensus and emphasize individualized treatment planning supported by accurate imaging evaluation (NCCN, 2026).

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Evidence Discussion

Imaging criteria for salivary gland cancers are supported by evidence demonstrating that accurate characterization of tumor extent, perineural involvement, and regional spread is critical for prognosis and treatment selection (NCI, 2024; NCCN, 2026). Clinical evidence indicates that tumor stage is a stronger predictor of outcome than histologic grade alone, reinforcing the importance of thorough imaging-based staging. Detection of extraparenchymal extension, nodal metastases, or distant disease alters management toward more aggressive local therapy or systemic treatment options. Imaging thereby prevents undertreatment of advanced disease and avoids unnecessary surgery in cases where unresectable or metastatic disease is present (NCI, 2024).

Because salivary gland cancers are rare and heterogeneous, most evidence guiding imaging strategies is derived from retrospective studies and expert consensus rather than randomized trials. Nonetheless, consistent data support the central role of high-quality cross-sectional imaging in optimizing outcomes while minimizing morbidity. Adherence to structured imaging criteria ensures appropriate use of advanced imaging, reduces diagnostic uncertainty, and supports multidisciplinary decision-making aligned with evidence-based practice (NCI, 2024; NCCN, 2026).

Health Equity Considerations

Salivary gland cancers are rare and biologically heterogeneous malignancies with documented disparities in incidence, treatment, and survival across racial, sex, and socioeconomic groups. Population-based analyses demonstrate that Black individuals experience worse disease-specific survival than White individuals, even after adjustment for age, tumor stage, histology, and treatment variables, with particularly pronounced disparities observed in mucoepidermoid and squamous cell carcinoma subtypes (Russell et al., 2014). These outcome differences are partly attributable to lower rates of definitive surgical management among Black individuals, suggesting potential delays in diagnosis, incomplete staging, or barriers to timely referral and specialty care that may directly affect the appropriateness and timing of diagnostic imaging (Russell et al., 2014). Given the importance of imaging for local tumor characterization, nodal assessment, and surgical planning, such disparities may contribute to variation in initial disease evaluation and management.

Socioeconomic factors also play a significant role in survival outcomes for individuals with salivary gland malignancies. Higher income levels have been associated with improved overall survival, particularly among male individuals, highlighting the influence of economic resources on access to care and treatment continuity (Cunningham et al., 2026). Individuals from lower socioeconomic backgrounds may face barriers to timely diagnostic imaging, comprehensive assessment of locoregional and nodal disease, and standardized post-treatment surveillance, increasing the risk of delayed intervention or under-monitoring. Given the wide histologic diversity of salivary gland tumors and their

complex anatomic considerations, consistent application of evidence-based imaging guidelines for diagnosis, staging, and follow-up supports health equity by promoting uniform evaluation frameworks across care settings and facilitating equitable access to appropriate oncologic management regardless of race, sex, or socioeconomic status (Cunningham et al., 2026; Russell et al., 2014).

Oncology Imaging Guidelines

Salivary Gland Cancers – Initial Work-up/ Staging (ONC-4.2)

ON.SG.0004.2.A
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Criteria

Indication	Medically Necessary Imaging Study
Biopsy-proven salivary gland malignancy	ONE of the following: • MRI Orbits/Face/Neck without and with contrast (CPT® 70543) • CT Neck with contrast (CPT® 70491) • CT Neck without contrast (CPT® 70490)
Skull base invasion in individuals with salivary gland cancers	• MRI Brain without and with contrast (CPT® 70553)
Individuals with salivary gland cancers with: • Adenoid cystic carcinoma • Lymphadenopathy in the neck • Pulmonary signs or symptoms • Abnormal chest x-ray	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250)
Inconclusive findings on conventional imaging in individuals with salivary gland cancers	• PET/CT (CPT® 78815)

Background and Supporting Information

Accurate initial staging is essential due to varied patterns of local extension, perineural spread, and distant metastasis across histologic subtypes (NCI, 2024; Broski et al., 2022). Histologic subtype influences growth patterns and routes of dissemination. Adenoid cystic carcinoma is notable for a high propensity for perineural spread and skull base involvement, often extending intracranially along cranial nerves. Other high grade tumors demonstrate increased risk of regional nodal disease and distant metastases, most commonly to the lungs and bones. These biologic characteristics necessitate tailored imaging assessment to accurately define disease extent at diagnosis (Seo et al., 2015; Larson & Wiggins, 2019).

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Evidence Discussion

Imaging strategies for initial work-up and staging of salivary gland cancers are supported by evidence demonstrating that complete anatomic and biologic characterization influences prognosis and management. MRI of the primary site provides superior evaluation of tumor extent, fascial plane invasion, and perineural spread, features that are strongly associated with recurrence risk and treatment planning. CT offers important adjunctive information for cortical bone involvement and surgical planning, and restricting modality selection to one comprehensive neck study minimizes unnecessary radiation exposure (Broski et al., 2022; Gule-Monroe et al., 2023).

Assessment for skull base invasion is critical, particularly in adenoid cystic carcinoma, where intracranial extension along cranial nerves may alter surgical approach or render disease unresectable. MRI of the brain and skull base has demonstrated higher sensitivity than CT for detecting perineural and intracranial spread, ensuring accurate staging and preventing undertreatment of advanced disease (Seo et al., 2015; Yousem et al., 2000).

Selective chest imaging is supported by evidence indicating that distant metastases, although uncommon overall, occur more frequently in higher-grade tumors, with lungs representing the most common site. Limiting chest CT to individuals with lymphadenopathy, pulmonary findings, or tumor subtypes at higher metastatic risk balances early detection of clinically relevant metastases against the harms of routine imaging in low-risk cases (Ma & Liu, 2020; Mimica et al., 2020; NCI, 2024).

FDG-PET/CT is best reserved for cases with inconclusive conventional imaging. While PET can identify metabolically active disease and distant metastases, variable FDG avidity across salivary gland tumor subtypes and overlap with benign entities (e.g., Warthin tumor) limit its routine use. Employing PET selectively reduces false-positive findings and downstream interventions while preserving its value in complex diagnostic scenarios where management would be altered by additional findings (Larson & Wiggins, 2019; Nakajima et al., 2021; Bianchini et al., 2023).

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Salivary Gland Cancers – Restaging/ Recurrence (ONC-4.3)

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Criteria

Indication	Medically Necessary Imaging Study
After complete surgical resection in individuals with salivary gland cancers	One-time imaging to establish baseline within 3-4 months of surgical resection is considered medically necessary using ONE of the following: • MRI Orbits/Face/Neck without and with contrast (CPT® 70543) • CT Neck with contrast (CPT® 70491) • CT Neck without contrast (CPT® 70490)
Individuals with salivary gland cancers with unresected disease receiving systemic therapy (chemotherapy)	Every 2 cycles: • CT Neck with contrast (CPT® 70491) OR MRI Orbits/Face/Neck without and with contrast (CPT® 70543) • CT with contrast or MRI without and with contrast for any other sites of disease
Recurrence or progression suspected based on new or worsening signs or symptoms in individuals with salivary gland cancers	ONE of the following: • CT Neck with contrast (CPT® 70491) • MRI Orbits/Face/Neck without and with contrast (CPT® 70543) In addition, for all individuals: • CT Chest with contrast (CPT® 71260)
Inconclusive findings on conventional imaging in individuals with salivary gland cancers	• PET/CT (CPT® 78815)
All other individuals with salivary gland cancers	• No routine advanced imaging

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Background and Supporting Information

Restaging and evaluation for recurrence in salivary gland cancers are directed at detecting clinically meaningful disease while accounting for variable tumor biology and patterns of failure. Following definitive treatment, most commonly surgical resection with or without adjuvant therapy, establishing a post-treatment baseline is important to distinguish expected postoperative or post-radiation changes from residual or recurrent tumor. The need for subsequent imaging is guided by treatment status, symptoms, and known sites of disease rather than routine fixed surveillance (NCCN, 2026; Gule Monroe et al., 2023).

Patterns of recurrence depend on histologic subtype and stage at diagnosis. Local and regional recurrences predominate after surgery, whereas distant metastases, most frequently to the lungs, are more common at recurrence than at initial presentation, particularly in high grade tumors and adenoid cystic carcinoma. Ongoing risk of late recurrence, especially in tumors with perineural spread, necessitates symptom directed imaging strategies rather than indiscriminate long term surveillance (Mimica et al., 2020; Ma & Liu, 2020).

Evidence Discussion

Evidence supports a one-time post-resection imaging study with CT or MRI to establish a new baseline for future comparison, as postoperative changes may persist and evolve over months. Establishing this reference standard improves diagnostic confidence on subsequent studies and reduces false-positive interpretation of expected postoperative findings. Additional routine imaging beyond this baseline has not demonstrated outcome benefit in asymptomatic individuals without unresected disease (NCCN, 2026; Gule-Monroe et al., 2023).

For individuals with unresected disease undergoing systemic therapy, interval cross-sectional imaging every two cycles is supported to assess response, guide continuation or modification of therapy, and detect early progression. Imaging of other involved sites is included to provide a comprehensive assessment of disease burden. This approach balances timely detection of progression with minimization of unnecessary imaging, as treatment decisions are directly linked to measurable response (Broski et al., 2022; Geiger et al., 2021).

When recurrence or progression is suspected based on new or worsening signs or symptoms, contrast-enhanced CT or MRI of the neck is supported to evaluate the primary site and regional nodes. CT of the chest is indicated concurrently, as the incidence of pulmonary metastases is substantially higher at recurrence than at initial diagnosis; published series report that a majority of metastatic recurrences involve the chest, often in the absence of respiratory symptoms. Use of intravenous contrast improves detection of nodal and mediastinal disease (Mimica et al., 2020; Ma & Liu, 2020).

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FDG-PET/CT is reserved as a problem-solving tool for inconclusive findings on conventional imaging. Limiting PET use in this setting avoids false-positive results related to postoperative or treatment-related inflammation and reduces unnecessary downstream interventions. This selective strategy aligns diagnostic benefit with patient safety and resource stewardship while preserving PET utility when management would change based on additional metabolic information (Nakajima et al., 2021; Larson & Wiggins, 2019).

Oncology Imaging Guidelines

Salivary Gland Cancers – Surveillance/ Follow-up (ONC-4.4)

ON.SG.0004.4.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Total surgical resection in individuals with salivary gland cancers	Every 6-12 months for up to 2 years: • CT Neck with contrast (CPT® 70491) AND • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250)
Unresectable or partially resected disease in individuals with salivary gland cancers, including those treated with radiation therapy	• Either CT Neck with contrast (CPT® 70491) or MRI Orbits/Face/Neck without and with contrast (CPT® 70543) once within 6 months of completion of treatment
Adenoid cystic carcinoma	ANY of the following, annually for up to 10 years: • CT Neck with contrast (CPT® 70491) or MRI Orbits/Face/Neck without and with contrast (CPT® 70543) • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250)

Background and Supporting Information

Surveillance following treatment for salivary gland cancers is focused on detection of clinically meaningful recurrence while minimizing unnecessary imaging. These tumors demonstrate heterogeneous biologic behavior based on histologic subtype, grade, and extent of disease at diagnosis. For most salivary gland malignancies, the risk of recurrence is highest within the first few years following treatment and is often heralded by patient-reported symptoms or abnormal findings on physical examination rather than routine imaging (NCCN, 2026, NCI, 2024).

Adenoid cystic carcinoma represents a distinct clinical entity within salivary gland cancers due to its indolent but persistent natural history, marked propensity for perineural spread, and high rate of late distant metastasis. Unlike other salivary gland malignancies, this subtype is associated with a prolonged risk of recurrence that may

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extend for a decade or more after initial treatment, necessitating extended imaging surveillance (Mimica et al., 2020; Ma & Liu, 2020).

Evidence Discussion

For individuals who have undergone total surgical resection of salivary gland cancer, evidence supports limited surveillance imaging during the first two years after treatment with imaging of the primary site and chest every 6 to 12 months. ASCO guidelines note that surveillance imaging of the primary site may be obtained every 6 to 12 months during the first two years following treatment, reflecting the period when recurrence risk is greatest. Beyond this period, follow-up is primarily guided by symptoms and physical examination findings rather than routine imaging, as evidence demonstrating improved outcomes from prolonged routine surveillance is limited (Geiger et al., 2021).

For individuals with unresectable or partially resected disease, or those treated with radiation therapy, a single post-treatment imaging study within six months is supported to establish a baseline for future comparison. This approach improves diagnostic confidence when evaluating subsequent clinical changes while avoiding excessive imaging once post-treatment anatomy has stabilized. Further imaging is guided by symptoms or clinical concern for progression rather than fixed surveillance intervals (Gule-Monroe et al., 2023; Broski et al., 2022).

Adenoid cystic carcinoma warrants a different surveillance strategy due to its distinct recurrence pattern. Multiple series demonstrate that this histology accounts for a disproportionate share of late metastatic recurrences, with more than 60% of individuals presenting with distant metastases at the time of recurrence and a median time to recurrence of approximately three years, with some occurring beyond ten years. Annual imaging of the neck and chest for up to ten years is therefore supported to enable detection of late locoregional or pulmonary recurrence that may be amenable to intervention (Mimica et al., 2020; Ma & Liu, 2020; NCI, 2024).

Routine surveillance PET/CT is not supported due to variable sensitivity across salivary gland tumor subtypes and increased likelihood of false-positive findings from postoperative or radiation-related changes. Restricting PET/CT to problem-solving scenarios aligns imaging use with evidence-based benefit and reduces downstream harm while preserving clinical utility in selected cases where management would be altered (Nakajima et al., 2021; Larson & Wiggins, 2019).

Oncology Imaging Guidelines

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v1.0.2027

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Melanomas and Other Skin Cancers (ONC-5)

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Melanoma – Suspected/Diagnosis (ONC-5.1)

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Criteria

Indication	Medically Necessary Imaging Study
All individuals with suspected melanoma	• Imaging is not considered medically necessary until histologic diagnosis is confirmed

Background and Supporting Information

Cutaneous melanoma is a malignant neoplasm arising from melanocytes and is diagnosed primarily through clinical examination followed by histopathologic confirmation. Definitive diagnosis requires tissue sampling, most commonly via excisional biopsy of the suspicious lesion with narrow margins. The diagnosis is based on histologic features including Breslow thickness, ulceration status, mitotic rate, and margin involvement, which together determine staging and guide subsequent management (NCCN, 2025).

Evidence Discussion

Evidence supports the exclusion of routine imaging during the suspected or diagnostic phase of melanoma evaluation. Multiple observational studies summarized in the NCCN Guidelines demonstrate that imaging performed prior to histologic confirmation has a very low yield for clinically meaningful findings, particularly in individuals with localized cutaneous lesions. Early melanoma rarely presents with detectable nodal or distant metastases, making imaging both inefficient and unlikely to influence diagnostic decision-making at this stage (NCCN, 2025).

Imaging before biopsy carries measurable risks, including false-positive findings that may lead to unnecessary anxiety, additional testing, invasive procedures, and delays in definitive diagnosis. Cross-sectional imaging and functional studies may also identify incidental findings unrelated to melanoma, further complicating care without providing diagnostic clarity (NCCN, 2025).

Histopathologic evaluation remains the gold standard for diagnosis and provides the critical prognostic variables required for staging and risk assessment. These parameters, particularly Breslow depth and ulceration, are superior predictors of regional and distant spread compared with any imaging modality in the absence of confirmed

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disease. Imaging cannot substitute for tissue diagnosis and does not improve diagnostic accuracy when used prematurely (NCCN, 2025).

Restricting imaging until after histologic confirmation aligns diagnostic practice with evidence-based risk-benefit principles. This approach minimizes unnecessary harm, conserves resources, and ensures that imaging, when eventually performed, is applied in clinically appropriate contexts where it can meaningfully guide staging and management decisions (NCCN, 2025).

Health Equity Considerations

Melanoma outcomes vary substantially by socioeconomic status, health care access, and health system structure, with consistent evidence of inequities in stage at diagnosis and melanoma-specific mortality. Lower socioeconomic status is strongly associated with later stage at presentation and higher risk of melanoma-related death, even among insured populations, reflecting delays in dermatologic evaluation and fragmented access to specialty care (Rosenthal et al., 2023). Individuals from lower socioeconomic backgrounds are more likely to present with thicker or more advanced tumors and experience barriers to coordinated diagnostic pathways, which may affect the timing, appropriateness, and intensity of staging and surveillance imaging (Cortez et al., 2021). In contrast, integrated health care systems demonstrate reduced socioeconomic gradients in stage at diagnosis and melanoma-specific survival, highlighting the role of system-level factors in mitigating disparities (Rosenthal et al., 2023).

Racial and ethnic minority populations, while experiencing lower overall melanoma incidence, are disproportionately diagnosed with advanced-stage disease and higher-risk subtypes, including acral and mucosal melanomas that are more difficult to detect clinically and often identified later in the disease course (Cortez et al., 2021; Shao & Feng, 2022). These disparities are closely linked to reduced access to dermatologic care, lower melanoma awareness, differences in clinical presentation, and insurance-related barriers rather than biological differences alone (Cortez et al., 2021; Shao & Feng, 2022). Delayed detection in these populations may necessitate more extensive imaging at presentation and limit opportunities for earlier-stage management. Consistent, evidence-based application of imaging guidelines for melanoma staging and follow-up supports health equity by promoting uniform assessment and longitudinal monitoring across diverse populations, regardless of race, ethnicity, or socioeconomic status (Rosenthal et al., 2023; Cortez et al., 2021).

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Melanoma – Initial Work-up/Staging (ONC-5.2)

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Criteria

Indication	Medically Necessary Imaging Study
Stage 0 or IA melanoma (in situ or disease less than 1mm)	• Routine advanced imaging is not considered medically necessary
• Stage IB melanoma (less than 0.8mm with ulceration or 0.8-1mm without or with ulceration) • Stage IIA and/or IIB or IIC melanoma with no adjuvant therapy planned (lesions greater than 1mm thick, but node negative)	• CT with contrast or MRI without and with contrast of specific areas, only if signs or symptoms indicate need for further evaluation
For sentinel lymph node evaluation in stages IB and II melanoma	• Lymph system imaging (lymphoscintigraphy, CPT® 78195) ◦ SPECT/CT (CPT® 78830) if requested
Any of the following: • Stage IIB and IIC melanoma prior to planned adjuvant therapy • Stage III melanoma (sentinel node positive, palpable regional nodes) • Stage IV melanoma (metastatic)	• MRI Brain without and with contrast (CPT® 70553) AND one of the following: • PET/CT (CPT® 78815 or CPT® 78816) OR • CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177)
• Head or neck primary site of melanoma • Palpable lymphadenopathy in the neck in individuals with melanoma • Mucosal melanoma of the head or neck region	In addition to above initial staging imaging, if PET/CT not performed: • CT Neck with contrast (CPT® 70491)

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Indication	Medically Necessary Imaging Study
• Primary site of melanoma is unknown **and** CT Chest, Abdomen, and Pelvis are negative	• PET/CT (CPT® 78815 or CPT® 78816)

Background and Supporting Information

Cutaneous melanoma is staged using clinicopathologic parameters that include Breslow thickness, ulceration, mitotic rate, lymph node involvement, and the presence of distant metastases. Most individuals present with localized disease; population based data indicate that the majority of melanomas are diagnosed at early stages, with a favorable prognosis following surgical excision alone. Accurate pathologic staging is therefore central to determining the need for additional diagnostic evaluation or imaging (NCCN, 2025; Siegel et al., 2025).

Early stage melanoma (stage 0 or IA) carries an excellent prognosis, with very low risk of nodal or distant metastatic disease. Survival rates for localized melanoma exceed 98%, reflecting the effectiveness of surgical management alone. As tumor thickness and adverse histologic features increase, the risk of regional nodal involvement rises, prompting consideration of sentinel lymph node evaluation to refine staging and prognostication (NCCN, 2025; Melanoma Research Alliance).

Evidence Discussion

Evidence supports withholding routine advanced imaging in individuals with stage 0 or IA melanoma because the prevalence of occult metastatic disease is extremely low and imaging has not demonstrated clinical benefit in this population. Studies consistently show a high false-positive rate and low diagnostic yield when imaging is used for screening asymptomatic patients with thin melanomas, exposing individuals to unnecessary radiation and additional procedures without improving outcomes (NCCN, 2025; Schröer-Günther et al., 2012).

For stage IB and II melanoma, sentinel lymph node evaluation is supported as an effective staging tool, while routine cross-sectional imaging is limited to scenarios in which signs or symptoms raise concern for metastatic disease. The likelihood of detecting distant metastases in asymptomatic individuals at these stages remains low, and indiscriminate imaging is associated with false-positive findings and increased healthcare utilization without survival benefit. Imaging in this setting is therefore justified only for targeted clinical indications or surgical planning (NCCN, 2025; Kappelin et al., 2022).

In contrast, individuals with stage III or IV melanoma have a significantly higher burden of metastatic disease, supporting comprehensive staging with PET/CT or CT chest, abdomen, and pelvis, along with baseline MRI of the brain. PET/CT has demonstrated

superior sensitivity compared with conventional CT for detecting distant metastases, while MRI brain is necessary given the high cumulative risk of CNS involvement, which is reported in up to one-third or more of patients with advanced disease (NCCN, 2025; Schröer-Günther et al., 2012).

When the primary site of melanoma is unknown or when conventional imaging is negative despite clinical suspicion, PET/CT is supported due to its ability to evaluate the entire body, including extremities, with high sensitivity. Restricting advanced imaging to higher-risk stages and defined clinical scenarios balances the benefits of accurate staging against potential harms, including radiation exposure, overdiagnosis, and delays in treatment, and reflects evidence-based imaging stewardship (NCCN, 2025; Siegel et al., 2025).

Oncology Imaging Guidelines

Melanoma – Restaging/Recurrence (ONC-5.3)

ON.SC.0005.3.C
v1.0.2027

Criteria

- All recurrences should be confirmed histologically, except when excessive morbidity from a biopsy may occur, such as a biopsy requiring craniotomy

Indication	Medically Necessary Imaging Study
Individuals with melanoma receiving chemotherapy, with measurable disease, after every 2 cycles	• CT Chest with contrast (CPT® 71260); **and** CT Abdomen and Pelvis with contrast (CPT® 74177) In addition, for individuals receiving systemic treatment for brain metastases: • MRI Brain without and with contrast (CPT® 70553)
All in situ recurrences of melanoma	• Restaging imaging is not considered medically necessary after adequate aggressive local therapy (See Surveillance)
Documented or clinically suspected (see top of page regarding biopsy morbidity) recurrence of melanoma at: • True scar recurrence (if re-excision suggests more than in situ disease) • In-transit disease • Regional lymph nodes • Metastatic site	• CT Chest with contrast (CPT® 71260); **and** CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Brain without and with contrast (CPT® 70553) In addition, for head or neck primary: • CT Neck with contrast (CPT® 70491)
ANY of the following in individuals with melanoma: • Inconclusive findings on conventional imaging • Isolated metastatic site found on conventional imaging	• PET/CT (CPT® 78815 or CPT® 78816)

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Indication	Medically Necessary Imaging Study
Brain imaging in individuals with melanoma for: • New discovery of metastatic disease or progression of metastatic disease • Signs or symptoms of CNS disease • If considering Interleukin (IL-2) therapy	• MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Melanoma recurrence may occur locally at the primary excision site, in transit along lymphatic channels, within regional lymph nodes, or at distant metastatic sites. The pattern and timing of recurrence are strongly influenced by the initial stage and biologic features of the primary tumor. While early stage melanoma carries a low risk of recurrence, individuals with regional nodal involvement or distant metastases are at substantially increased risk for subsequent disease progression, including central nervous system involvement (NCCN, 2025; Siegel et al., 2025).

Histologic confirmation of recurrence is fundamental to management, as imaging findings alone cannot reliably distinguish melanoma recurrence from benign postoperative or inflammatory processes. Exceptions are limited to scenarios in which biopsy would result in excessive morbidity, such as lesions requiring craniotomy. Accurate confirmation ensures that imaging based restaging is applied to individuals with clinically meaningful disease (NCCN, 2025).

Evidence Discussion

Evidence supports the use of interval CT chest, abdomen, and pelvis for individuals receiving systemic therapy for recurrent or metastatic melanoma with measurable disease, typically performed every two treatment cycles. This approach allows timely assessment of therapeutic response or progression while avoiding excessive imaging frequency. CT provides reliable evaluation of visceral and nodal disease, which are common sites of melanoma recurrence (NCCN, 2025; Schröer-Günther et al., 2012).

In contrast, in situ recurrences have an excellent prognosis following adequate local therapy and do not warrant restaging imaging. Published data demonstrate a very low likelihood of systemic spread in this setting, and routine imaging would expose individuals to unnecessary radiation and false-positive findings without clinical benefit (NCCN, 2025; Melanoma Research Alliance).

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For documented or clinically suspected recurrence involving the primary site, in-transit disease, regional lymph nodes, or distant metastases, comprehensive restaging with CT Chest/Abdomen/Pelvis and MRI Brain is supported. Melanoma has one of the highest rates of CNS metastases among solid tumors, and brain involvement may be present even in the absence of neurologic symptoms. MRI provides superior sensitivity for detecting intracranial disease and is therefore considered medically necessary in these contexts (NCCN, 2025; Schröer-Günther et al., 2012).

PET/CT is reserved for problem-solving scenarios, such as inconclusive conventional imaging or evaluation of a solitary metastatic focus. Limiting PET use reflects evidence showing that indiscriminate PET imaging increases false-positive findings and downstream interventions without improving outcomes. MRI brain is additionally required for new or progressive metastatic disease, neurologic signs or symptoms, or when considering interleukin-2 therapy, given the treatment-related risks associated with occult CNS metastases (NCCN, 2025).

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Melanoma – Surveillance/Follow-up (ONC-5.4)

ON.SC.0005.4.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Stage 0, IA, IB and IIA melanomas	• No routine advanced imaging
Stage IIB, IIC, IIIA and IIIB melanomas	• CT Chest (CPT® 71260) **and** CT Abdomen and Pelvis (CPT® 74177) with contrast every 6 months for 2 years, then annually for 3 years • For melanoma arising from extremities, advanced imaging of the primary site is not routinely considered medically necessary for surveillance in asymptomatic individuals.
Stage IIIC and IV melanomas	• CT Chest (CPT® 71260) **and** CT Abdomen and Pelvis (CPT® 74177) with contrast every 3 months for 2 years, then every 6 months for 3 years • MRI Brain without and with contrast (CPT® 70553) annually for 3 years • For melanoma arising from extremities, advanced imaging of the primary site is not routinely considered medically necessary for surveillance in asymptomatic individuals.
Mucosal melanoma of the head or neck region	In addition to above stage-based surveillance imaging, ONCE within 6 months of completing all treatment: • CT Neck with contrast (CPT® 70491) or MRI Orbits/Face/Neck without and with contrast (CPT® 70543) • CT with contrast of any other involved body area
Liver metastases treated with focal therapy	• See: **Liver Metastases (ONC-31.2)**

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Indication	Medically Necessary Imaging Study
Vulvar or vulvovaginal melanoma stage 0, IA, IB and IIA	Ultrasound of the Abdomen (CPT® 76700 or 76705) and/or Pelvis (CPT® 76856 or 76857)
Vulvar or vulvovaginal melanoma stage IIB or higher	CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) every 3 months for 2 years, and then every 6 months for 3 years

Background and Supporting Information

Surveillance strategies in melanoma are driven by the strong relationship between disease stage and risk of recurrence. Most individuals with early stage melanoma remain disease free following definitive local therapy, whereas those with more advanced stages face a significantly higher likelihood of locoregional or distant recurrence, often within the first several years after treatment. Follow up approaches are therefore deliberately risk stratified to balance early detection of clinically meaningful recurrence against the harms of unnecessary imaging (NCCN, 2025; Garbe et al., 2003).

Evidence Discussion

Evidence consistently shows that routine advanced imaging does not improve outcomes for individuals with stage 0, IA, IB, or IIA melanoma. In these groups, the majority of recurrences are identified clinically, and imaging surveillance yields a very low rate of actionable findings. Studies demonstrate substantial false-positive rates, increased anxiety, added costs, and exposure to cumulative radiation without a corresponding survival benefit, supporting omission of routine imaging in early-stage disease (Garbe et al., 2003; NCCN, 2025).

As melanoma stage increases, both the likelihood and tempo of recurrence rise, justifying structured imaging surveillance in stage IIB through IIIB disease. Data indicate that recurrence risk declines markedly after approximately 2–3 years, supporting more frequent CT chest/abdomen/pelvis imaging early in surveillance followed by longer intervals thereafter. CT is favored over PET/CT in this setting due to adequate sensitivity for visceral disease and a lower rate of false-positive findings (Garbe et al., 2003; NCCN, 2025).

Stage IIIC and IV melanoma are associated with a particularly high risk of early systemic and intracranial recurrence. Regular CT surveillance is supported to detect rapidly progressive metastatic disease, while annual MRI of the brain is necessary given the substantial incidence of brain metastases in advanced melanoma. CNS involvement has significant prognostic and therapeutic implications, particularly in the era of immune checkpoint inhibitors and targeted therapies (NCCN, 2025; van Opijnen et al., 2019).

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The limited utility of routine PET/CT in surveillance, particularly in sentinel node–positive stage III melanoma, supports the preferential use of CT-based imaging strategies. Evidence shows a low proportion of true-positive PET findings and a higher incidence of false-positive results that may prompt unnecessary interventions. Surveillance strategies that align imaging intensity with recurrence risk optimize early detection where beneficial while minimizing harm in lower-risk populations (Garbe et al., 2003; NCCN, 2025).

Oncology Imaging Guidelines

Non-Melanoma Skin Cancers – General Considerations (ONC-5.5)

ON.SC.0005.5.A
v1.0.2027

Criteria

- Advanced imaging is generally not considered medically necessary for basal cell and squamous cell skin cancers.
- PET/CT scan is not considered medically necessary for evaluation of non-melanoma skin cancers unless specified within the guidelines below (e.g., Merkel cell carcinoma).

Background and Supporting Information

Non-melanoma skin cancers (NMSCs) primarily include basal cell carcinoma (BCC) and cutaneous squamous cell carcinoma (cSCC), which together represent the most common malignancies diagnosed worldwide. These tumors arise from keratinocytes and most frequently occur on chronically sun-exposed skin. The vast majority of BCCs and cSCCs demonstrate indolent local behavior and are effectively managed with local therapies such as surgical excision or Mohs micrographic surgery, without need for systemic staging or imaging (Shreve et al., 2020).

Basal cell carcinoma is characterized by slow growth and a very low risk of metastasis, typically confined to locally destructive behavior if untreated. Cutaneous squamous cell carcinoma carries a slightly higher risk of regional nodal spread and distant metastasis than BCC, particularly in the presence of high risk features such as large tumor size, deep invasion, poor differentiation, perineural invasion, immunosuppression, or high risk anatomic sites (e.g., ear, lip) (Shreve et al., 2020). Even in these cases, systemic dissemination remains uncommon.

Merkel cell carcinoma (MCC) is biologically distinct from other NMSCs. It is a rare, aggressive neuroendocrine carcinoma of the skin with a marked propensity for early regional lymph node involvement and distant metastatic spread, including visceral and pulmonary metastases. MCC may arise as a primary cutaneous malignancy or represent cutaneous involvement by a non cutaneous neuroendocrine carcinoma, such as small cell lung cancer, necessitating a different diagnostic and imaging approach (NCCN, 2026).

Evidence Discussion

Clinical evidence strongly supports the position that routine advanced imaging, including PET/CT, is not supported for basal cell carcinoma or most cutaneous squamous cell

carcinomas. Long-term observational studies demonstrate that metastatic BCC is exceedingly rare, with reported rates well under 1% even after extended follow-up, and that most lesions are successfully treated with local therapy alone (Shreve et al., 2020). Imaging in these cases provides little diagnostic yield and introduces unnecessary radiation exposure and potential false-positive findings.

Metastatic cSCC is also uncommon, particularly in low-risk tumors, with most cases of spread occurring in tumors with clearly defined high-risk clinicopathologic features. Even in high-risk cSCC, regional lymph node involvement is more frequent than distant metastasis, and imaging is best reserved for selected cases guided by clinical concern rather than applied routinely. This selective approach minimizes overuse of imaging while maintaining sensitivity for clinically meaningful disease (Shreve et al., 2020).

In contrast, Merkel cell carcinoma demonstrates substantially different behavior, with published data indicating regional lymph node involvement in approximately 25%–33% of patients at presentation and a significant risk of distant metastatic spread. Multiple studies summarized in the NCCN Guidelines show that imaging frequently leads to disease upstaging and changes in management, supporting a lower threshold for advanced imaging in MCC compared with other NMSCs (NCCN, 2026).

Distinguishing primary MCC from cutaneous metastasis of a non-cutaneous neuroendocrine carcinoma has important prognostic and therapeutic implications. Imaging is therefore essential in suspected MCC to evaluate nodal basins and distant organs, particularly the lungs, where metastatic disease may originate or preferentially spread. Restricting intensive imaging strategies to MCC while avoiding routine use in BCC and cSCC aligns diagnostic benefit with tumor biology and avoids unnecessary harm from low-yield imaging in indolent disease (NCCN, 2026).

Health Equity Considerations

Non-melanoma skin cancers (NMSCs) demonstrate important disparities in disease severity, presentation, and outcomes across racial, ethnic, and socioeconomic groups. Although NMSCs are less common in individuals of color, Hispanic/Latino patients have been shown to present with significantly larger tumor burdens at the time of definitive treatment, as reflected by larger Mohs micrographic surgery defect sizes, suggesting later diagnosis and more advanced disease at presentation (Blumenthal et al., 2022). These disparities are further influenced by insurance type, with publicly insured and HMO-insured individuals demonstrating larger defect sizes compared with those with private insurance, highlighting the role of access to timely dermatologic evaluation and treatment (Blumenthal et al., 2022).

Individuals of racial and ethnic minority groups are also more likely to develop NMSCs in anatomically or clinically less conspicuous locations and may experience delays due to lower skin cancer risk awareness, limited access to dermatologists, and reduced exposure to preventive education (Shao & Feng, 2022). Such delays can result in more

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locally advanced disease requiring more extensive surgical management and, in select cases, advanced imaging for assessment of perineural invasion, regional spread, or high-risk features. Consistent application of guideline-based imaging for high-risk NMSC is important to support equitable staging, treatment planning, and follow-up across diverse populations.

Oncology Imaging Guidelines

Non-Melanoma Skin Cancers – Initial Work-up/Staging (ONC-5.6)

ON.SC.0005.6.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Body area with unexplained signs or symptoms in individuals with non-melanoma skin cancers	• CT with contrast of that body area
Perineural invasion or local regional extension (i.e., bone; deep soft tissue) involvement in individuals with non-melanoma skin cancers	ONE of the following of the primary site: • MRI without contrast **or** without and with contrast • CT (contrast as requested)
Skin lesion may be a dermal metastasis from distant primary in individuals with non-melanoma skin cancers	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • PET/CT (CPT® 78815 or CPT® 78816) if conventional imaging (CT or MRI) is unable to identify a primary site
Squamous cell carcinoma head or neck skin with regional lymphadenopathy	• CT Neck (CPT® 70491) and CT Chest (CPT® 71260) with contrast
Merkel Cell carcinoma	• Lymph system imaging (lymphoscintigraphy, CPT® 78195) for sentinel lymph node evaluation ◦ SPECT/CT (CPT® 78830) if requested) • PET/CT (CPT® 78815 or CPT® 78816) OR CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of other involved body area(s)

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Indication	Medically Necessary Imaging Study
Signs or symptoms of CNS involvement in individuals with non-melanoma skin cancers	• MRI Brain with and without contrast (CPT® 70553)

Background and Supporting Information

Non-melanoma skin cancers (NMSC) include basal cell carcinoma (BCC), cutaneous squamous cell carcinoma (cSCC), and rare aggressive entities such as Merkel cell carcinoma (MCC). BCC and cSCC arise from keratinocytes and are predominantly diagnosed at an early stage through clinical examination and biopsy. Most cases are localized and adequately characterized by physical examination and histopathology, with imaging reserved for situations where clinical assessment is insufficient to determine disease extent (NCCN, 2026).

Evidence Discussion

Available evidence supports a targeted imaging approach for initial work-up and staging of non-melanoma skin cancers based on clinical risk. For most BCC and low-risk cSCC, imaging is not routinely supported because disease is localized and adequately staged through clinical examination and biopsy alone. Imaging is reserved for body areas with unexplained symptoms or when physical examination cannot reliably assess the extent of disease, avoiding unnecessary radiation exposure and low-yield testing (NCCN, 2026).

When perineural invasion or deep local extension is suspected, imaging provides critical anatomic information that directly affects treatment planning. MRI has demonstrated superior sensitivity for detecting perineural tumor spread and deep soft-tissue involvement, while CT is more effective for identifying cortical bone invasion. Selecting modality based on suspected pattern of spread optimizes diagnostic accuracy and minimizes redundant imaging (NCCN, 2026).

In cases where a skin lesion is suspected to represent a dermal metastasis from a distant primary tumor, CT of the chest, abdomen, and pelvis is supported to identify the source malignancy. PET/CT is reserved for situations in which conventional imaging fails to identify a primary site, particularly when disease distribution suggests an origin outside the imaged field (NCCN, 2026).

Merkel cell carcinoma warrants comprehensive imaging at diagnosis due to its aggressive natural history. Evidence summarized in NCCN guidelines demonstrates that FDG-PET/CT frequently detects clinically occult nodal or distant disease and results in disease upstaging that alters management. Sentinel lymph node mapping is also supported for accurate regional staging. This imaging-intensive approach for MCC

contrasts with the conservative imaging strategy appropriate for BCC and most cSCC, aligning diagnostic intensity with tumor biology and risk (NCCN, 2026).

Oncology Imaging Guidelines

Non-Melanoma Skin Cancers – Restaging/Recurrence (ONC-5.7)

ON.SC.0005.7.A
v1.0.2027

Criteria

- All recurrences should be confirmed histologically, except when excessive morbidity from a biopsy may occur, such as a biopsy requiring craniotomy.

Indication	Medically Necessary Imaging Study
Recurrence of non-melanoma skin cancer where planned therapy is more extensive than simple wide local excision	• CT with contrast of the primary and recurrent site(s)
Suspected recurrence of Merkel cell carcinoma	• CT Chest (CPT® 71260) **and** CT Abdomen and Pelvis (CPT® 74177) with contrast • CT with contrast of other symptomatic body area(s)
For the following (for Merkel cell carcinoma): • Inconclusive findings on conventional imaging • If no conventional imaging has been performed, and ONE of the following: ◦ Biopsy-proven recurrence ◦ Suspected in-transit metastatic disease from a primary site in the extremities	• PET/CT (CPT® 78815 or 78816)

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Indication	Medically Necessary Imaging Study
Signs or symptoms of CNS involvement in individuals with non-melanoma skin cancers	• MRI Brain without and with contrast (CPT® 70553)
Treatment response in individuals with Merkel cell carcinoma	Every 2 cycles: • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • CT with contrast of other symptomatic body area(s)

Background and Supporting Information

Restaging and evaluation for recurrence in non-melanoma skin cancers (NMSC) are guided by tumor biology, histology, and anticipated treatment complexity. Basal cell carcinoma (BCC) and cutaneous squamous cell carcinoma (cSCC) most often recur locally and remain amenable to surgical management, whereas Merkel cell carcinoma (MCC) demonstrates a substantially higher risk of regional and distant metastatic recurrence. Accurate confirmation of recurrence is essential before advanced imaging is pursued, as benign postoperative or inflammatory changes can mimic recurrent disease on imaging alone (NCCN, 2026).

Histologic confirmation of recurrence is considered standard whenever feasible. Exceptions are limited to circumstances in which biopsy would impose excessive morbidity, such as intracranial disease requiring craniotomy. Establishing recurrent disease prior to imaging ensures that diagnostic studies are applied appropriately to cases where findings will directly influence management decisions (NCCN, 2026).

Evidence Discussion

Evidence supports the use of targeted CT imaging for recurrent non-melanoma skin cancers when treatment planning extends beyond localized excision. For BCC and cSCC, most recurrences are superficial or confined locally, and imaging is not routinely required unless deeper invasion or regional extension is suspected. When more extensive therapy is contemplated, CT with contrast of the primary and recurrent sites provides essential anatomic detail and avoids unnecessary imaging in cases manageable with local surgery alone (NCCN, 2026).

Merkel cell carcinoma recurrence carries a high probability of regional and distant metastatic disease, with recurrence frequently involving the chest, abdomen, pelvis, or other symptomatic sites. NCCN guidance supports CT Chest/Abdomen/Pelvis with contrast for suspected MCC recurrence, as this approach reliably identifies common

metastatic sites and informs decisions regarding systemic therapy versus localized intervention (NCCN, 2026).

PET/CT is reserved for specific clinical scenarios in MCC, including inconclusive findings on conventional imaging or evaluation of suspected in-transit metastases from primary tumors arising on the extremities. In these settings, PET/CT improves detection of metabolically active disease and delineates disease burden more accurately than anatomic imaging alone, thereby influencing staging and management. Limiting PET/CT to these contexts mitigates false-positive findings and unnecessary downstream interventions (NCCN, 2026).

MRI of the brain is supported only when signs or symptoms suggest central nervous system involvement. CNS metastases are uncommon in BCC and cSCC but may occur in advanced MCC. Symptom-directed brain imaging ensures timely detection of clinically significant disease while avoiding routine CNS imaging in asymptomatic individuals, aligning imaging intensity with demonstrated clinical risk (NCCN, 2026).

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Non-Melanoma Skin Cancers – Surveillance/Follow-up (ONC-5.8)

ON.SC.0005.8.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Merkel cell cancer with any of the following high-risk factors: • Stage II-IV • Individuals assigned male at birth • Immunosuppression • Merkel Cell polyomavirus negative status • Age 70 or higher • Non-sentinel lymph node metastases	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast every 6 months for 5 years • Add CT Neck with contrast (CPT® 70491) if known prior neck disease or scalp/facial/neck disease
All other individuals with non-melanoma skin cancers	• Routine advanced imaging for surveillance is not considered medically necessary • Imaging only for signs and symptoms of recurrent disease

Background and Supporting Information

Surveillance strategies for non-melanoma skin cancers (NMSC) are determined by tumor biology and recurrence risk. Basal cell carcinoma (BCC) and cutaneous squamous cell carcinoma (cSCC) typically demonstrate indolent behavior, with recurrences most often detected at the primary site through patient self report or physical examination. As a result, ongoing follow up for these cancers emphasizes clinical evaluation rather than routine imaging (NCCN, 2026).

Merkel cell carcinoma (MCC) represents a biologically distinct form of NMSC with aggressive clinical behavior and a high propensity for recurrence. Factors such as advanced stage, older age, immunosuppression, and male sex are associated with substantially increased recurrence risk. Patterns of recurrence in MCC often involve lymph nodes, lungs, liver, and other visceral organs, while central nervous

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system involvement is less common but clinically significant when present. Unlike BCC and cSCC, MCC frequently relapses with regional nodal or distant metastatic disease, prompting greater reliance on imaging during surveillance in selected high risk individuals (NCCN, 2026).

Evidence Discussion

Evidence supports the exclusion of routine advanced imaging for surveillance of BCC and cSCC in the absence of signs or symptoms of recurrence. Most relapses are detected clinically, and imaging has a low diagnostic yield in asymptomatic individuals. Data summarized in oncology surveillance literature demonstrate that routine imaging in low-risk cutaneous malignancies increases false-positive findings, healthcare utilization, and patient anxiety without improving survival or recurrence outcomes (NCCN, 2026; Rajagopal et al., 2024).

In contrast, MCC demonstrates substantially higher recurrence rates, particularly in node-positive and advanced-stage disease, with reported recurrence approaching one-third of patients within five years. Risk is further increased among individuals assigned male at birth, those aged 70 years or older, immunosuppressed individuals, and patients with polyomavirus-negative tumors or non-sentinel lymph node metastases. These data support structured imaging surveillance in high-risk MCC populations (NCCN, 2026c).

CT imaging of the chest, abdomen, and pelvis at defined intervals allows for detection of clinically occult metastases in common sites of MCC spread and may enable earlier initiation of systemic therapy. Additional CT imaging of the neck is justified when prior disease involved cervical lymph nodes or when primary tumors arise from the scalp, face, or neck. This targeted imaging strategy aligns surveillance intensity with biologic risk while avoiding unnecessary whole-body imaging in lower-risk individuals (NCCN, 2026).

Findings from broader cutaneous oncology surveillance studies reinforce this selective approach. Rajagopal et al. demonstrated that surveillance imaging provides limited benefit in low-risk skin cancer populations but may detect actionable recurrences in higher-risk groups. Applying imaging only to MCC patients with established high-risk features balances potential benefits of early detection against harms associated with over-imaging, including radiation exposure and false-positive results (Rajagopal et al., 2024).

Ocular Melanoma (ONC-5.9)

ON.SC.0005.9.A
v1.0.2027

Criteria

- Biopsy is usually not medically necessary for initial diagnosis of uveal melanoma but may be useful in cases when diagnosis is uncertain (e.g., amelanotic tumors, retinal detachment) or for prognostic analysis and risk stratification.
- Surveillance of the affected eye is with clinical examination only; advanced imaging is considered medically necessary for surveillance of systemic metastatic disease based on individual risk factors. See risk categories below for surveillance recommendations.

Ocular Melanoma Risk Categories

Low Risk	Medium Risk	High-Risk
T1	T2 and T3	T4
Class IA	Class IB	Class 2
Spindle cell histology	Mixed Spindle and Epitheloid cells	Epitheloid cell histology
No extraoccular extension	No extraoccular extension	Extraoccular extension present
No ciliary body involvement	No ciliary body involvement	Ciliary body involvement present
Chromosome mutations: • Disomy 3 • EIF1AX mutation • Gain of chromosome 6p	Chromosome mutations: • SF3B1 mutation	Chromosome mutations: • BAP1 mutation • PRAME mutation • Monosomy 3 • Gain of chromosome 8q

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Indication	Medically Necessary Imaging Study
Initial staging of suspected or biopsy-proven uveal melanoma	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177), OR MRI Abdomen without and with contrast (CPT® 74183) with CT Pelvis with contrast (CPT® 72193), OR MRI Abdomen without and with contrast (CPT® 74183) with MRI Pelvis without and with contrast (CPT® 72197) • MRI Orbits/Face/Neck without and with contrast (CPT® 70543)
Neurological signs/ symptoms in individuals with ocular melanoma	• MRI Brain without and with contrast (CPT® 70553)
Restaging/suspected recurrence of ocular melanoma	ANY or ALL of the following: • MRI Brain without and with contrast (CPT® 70553) • MRI Orbits/Face/Neck without and with contrast (CPT® 70543) • CT Chest with contrast (CPT® 71260) • PET/CT (CPT® 78815 or 78816) AND one of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) OR • MRI Abdomen without and with contrast (CPT® 74183) with CT Pelvis with contrast (CPT® 72193) OR ◦ Ultrasound Abdomen substituted for MRI Abdomen if requested • MRI Abdomen without and with contrast (CPT® 74183) with MRI Pelvis without and with contrast (CPT® 72197)
Surveillance for Low Risk ocular melanoma	Annually for 10 years: • CT Chest with contrast (CPT® 71260) • CT Abdomen with contrast (CPT® 74160) or MRI Abdomen without and with contrast (CPT® 74183)

Indication	Medically Necessary Imaging Study
Surveillance for Medium Risk ocular melanoma	Every 6 months up to year 10: • CT Chest with contrast (CPT® 71260) • CT Abdomen with contrast (CPT® 74160) or MRI Abdomen without and with contrast (CPT® 74183)
Surveillance for High-risk ocular melanoma	Every 3 months for 5 years, then every 6 months up to year 10: • CT Chest with contrast (CPT® 71260) • CT Abdomen with contrast (CPT® 74160) or MRI Abdomen without and with contrast (CPT® 74183)

Background and Supporting Information

Ocular melanoma is a rare malignancy, with approximately 95% arising from the uveal tract (choroid, ciliary body, and iris) and the remaining cases originating from the conjunctiva or orbit. Uveal melanoma represents the most common primary intraocular malignancy in adults but remains uncommon overall, with an incidence of approximately 5 cases per million annually in the United States. Most tumors are localized at diagnosis, and fewer than 3% of individuals present with detectable metastatic disease at initial evaluation (NCCN, 2025; Dennis et al., 2023).

Diagnosis of uveal melanoma is primarily clinical, based on comprehensive ophthalmologic examination and ocular imaging. Biopsy is not routinely required for diagnosis but may be appropriate when the diagnosis is uncertain or when molecular and cytogenetic testing is needed for prognostic stratification. Such testing has become increasingly important to estimate metastatic risk and guide systemic surveillance strategies (NCCN, 2025).

Treatment is directed at the affected eye using local modalities such as plaque brachytherapy, particle beam radiotherapy, stereotactic radiosurgery, or enucleation, depending on tumor size, location, and presence of extraocular extension. Systemic therapy is reserved for individuals with metastatic disease, as local treatment does not prevent the development of distant metastases that arise from early micrometastatic spread (NCCN, 2025; Dennis et al., 2023).

The liver is the predominant site of metastatic spread, involved in approximately 80%-90% of cases with distant disease. Other sites include the lungs, bone, skin/soft tissue, lymph nodes, and less commonly the brain. Surveillance of the treated eye is performed through clinical ophthalmologic examination, while advanced imaging is directed toward detection of systemic metastatic disease and is guided by individual risk stratification (NCCN, 2025).

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Evidence Discussion

Evidence supports focused imaging strategies in ocular melanoma that reflect the unique biologic behavior of the disease. Although the prevalence of metastatic disease at diagnosis is low, the lifetime risk of metastasis is substantial and strongly correlated with tumor stage, histology, and molecular characteristics. Reported five-year metastatic risk ranges from approximately 3%–5% in stage I disease to more than 40% in stage III disease, justifying baseline systemic staging despite low initial yield (NCCN, 2025; Dennis et al., 2023).

MRI of the orbits, face, and neck is supported at initial staging to evaluate extraocular extension, an important determinant of prognosis and local treatment planning. Identification of orbital involvement may alter management by favoring enucleation over radiation-based approaches. CNS imaging is not routinely required but is supported when neurologic signs or symptoms are present, as brain metastases, while uncommon, have significant clinical implications (NCCN, 2025).

Systemic imaging focuses on detection of liver metastases, given the overwhelming hepatic tropism of uveal melanoma. CT or MRI of the abdomen provides sensitive evaluation of hepatic disease, while CT of the chest addresses pulmonary involvement, the second most common metastatic site. Although surveillance imaging carries a low yield in early years for low-risk disease, long-term studies show cumulative metastatic rates may approach 70% over decades, supporting prolonged risk-based surveillance strategies (NCCN, 2025).

Surveillance intensity is therefore stratified by clinical stage, histologic features, and molecular risk markers such as gene expression profile class, chromosomal abnormalities (e.g., monosomy 3, gain of chromosome 8q), and specific mutations including BAP1, SF3B1, and EIF1AX. This approach balances the potential benefits of early detection of treatable metastatic disease against the harms of cumulative radiation exposure, false-positive findings, and low diagnostic yield in low-risk populations, an issue explicitly acknowledged by the NCCN as an area of ongoing debate (NCCN, 2025; Dennis et al., 2023; van Ryan et al., 2025).

Health Equity Considerations

Ocular melanoma, including uveal and conjunctival subtypes, demonstrates measurable disparities in stage at presentation, treatment patterns, and survival associated with socioeconomic status, insurance coverage, and broader social vulnerability. Large national database studies show that uninsured and Medicaid-insured individuals, as well as those in lower income quartiles, are significantly more likely to present with advanced tumor stage at diagnosis, increasing the need for definitive surgical management such as enucleation and limiting opportunities for globe-sparing therapy (Choudhry et al., 2024; Gomez et al., 2024). Higher composite social vulnerability, particularly related to socioeconomic status and housing-transportation barriers, is associated with shorter

survival and lower likelihood of receiving definitive surgical treatment, independent of tumor site (Mensah et al., 2024).

Racial and ethnic minority status and geographic barriers further contribute to inequities in ocular melanoma care. Systematic reviews and registry-based analyses demonstrate that non-White individuals and those with limited access to specialized ocular oncology centers experience higher rates of enucleation and less favorable outcomes, even when overall survival differences are inconsistent across studies (Shaughnessy et al., 2026; Gomez et al., 2024). Delays in diagnosis and referral may increase reliance on advanced imaging at presentation for tumor characterization, staging, and treatment planning. Consistent, guideline-based imaging, particularly in individuals with limited access to subspecialty care, is important to support equitable staging, appropriate management selection, and surveillance across diverse populations.

Oncology Imaging Guidelines

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v1.0.2027

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Thyroid Cancer (ONC-6)

Guideline Page

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Thyroid Cancer – General Considerations (ONC-6.0)

ON.TC.0006.0.A
v1.0.2027

Criteria

- Individuals of all ages with thyroid cancer are imaged according to this guideline.
- Whole-Body Thyroid Nuclear scan (also known as whole-body radioiodine scan) is coded with CPT® 78018. If CPT® 78018 is obtained and found to be positive, CPT® 78020 is considered medically necessary as an add-on test to evaluate the degree of iodine uptake.
- Single photon emission computed tomography (SPECT) imaging – Radiopharmaceutical Localization of Tumor SPECT (CPT® 78803 or CPT® 78831) or SPECT/CT Hybrid study (CPT® 78830 or CPT® 78832) may complement planar and pinhole imaging and is considered medically necessary as an add-on wherever radioiodine (RAI) scans are considered medically necessary.
- Whole-Body Thyroid Nuclear scan (also known as whole-body RAI scan) is the imaging modality of choice for differentiated thyroid cancers, as these are usually not well visualized on FDG-PET/CT scans. Individuals who have RAI-diagnostic scan negative and PET-positive disease will generally not respond to RAI treatment, whereas individuals who have PET-negative and RAI-diagnostic scan negative disease may still be candidates for empiric RAI treatment.

Background and Supporting Information

Thyroid carcinoma represents a heterogeneous group of malignancies arising from thyroid follicular or parafollicular cells and includes differentiated carcinomas (papillary, follicular, and oncocytic), medullary carcinoma, and anaplastic carcinoma. Differentiated thyroid cancers comprise the majority of cases and generally demonstrate favorable long term outcomes, with 10 year survival rates exceeding 90%–95% (NCCN, 2025).

Diagnosis is typically initiated by evaluation of a thyroid nodule, most commonly using ultrasound and fine needle aspiration (FNA) cytology, which remains the standard diagnostic approach. Molecular testing may further refine risk assessment and guide management in indeterminate cases. Although many thyroid nodules are benign, malignant nodules may present with suspicious clinical or imaging features such as rapid growth, local invasion, or regional lymphadenopathy. Long term management includes risk adapted surveillance using clinical evaluation, laboratory markers such as thyroglobulin, and selective imaging (NCCN, 2025).

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Evidence Discussion

Evidence supports the use of radioiodine (RAI) whole body scanning as a primary imaging modality in differentiated thyroid cancers due to its high sensitivity for iodine avid disease. RAI imaging allows detection of residual thyroid tissue and metastatic disease and serves as a companion to therapeutic RAI administration. Its diagnostic utility directly informs treatment planning and post therapy assessment, particularly in patients with known or suspected metastatic disease (NCCN, 2025).

The distinction between RAI avid and RAI refractory disease underpins imaging selection and therapeutic decision making. RAI refractory disease is defined by lack of uptake, loss of uptake over time, heterogeneous uptake patterns, or disease progression despite RAI uptake. Recognition of these patterns avoids ineffective repeat RAI therapy and reduces unnecessary radiation exposure, while guiding clinicians toward more appropriate systemic or targeted therapies (NCCN, 2025).

The complementary role of SPECT or SPECT/CT imaging enhances anatomic localization of radioiodine uptake, improving diagnostic accuracy without substantially increasing radiation burden when used as an adjunct. This combined functional anatomic approach provides added value in cases where planar imaging alone is insufficient to characterize disease distribution, especially in complex cervical or mediastinal anatomy (NCCN, 2025).

FDG PET/CT has a limited but clinically important role in thyroid cancer imaging. Evidence demonstrates that PET/CT is less sensitive for iodine avid differentiated thyroid cancers but may identify metabolically active disease in cases where RAI scans are negative. This is particularly relevant in RAI refractory disease, where PET positivity is associated with lack of response to further RAI therapy and may prompt consideration of alternative systemic treatments (NCCN, 2025). This risk adapted imaging strategy balances diagnostic benefit with potential harms, including cumulative radiation exposure and low yield imaging in indolent disease.

Health Equity Considerations

Racial, socioeconomic, and structural inequities influence diagnostic pathways and outcomes for individuals with thyroid cancer. Population-based analyses demonstrate that Black and Hispanic/Latino individuals are less likely to receive guideline-concordant surgical management and experience higher all-cause and thyroid cancer–specific mortality compared with non-Hispanic White individuals, with socioeconomic status accounting for a substantial proportion of these differences (Fwelo et al., 2025; Onadeko & Desai, 2025). Lower income, limited educational attainment, and lack of insurance are associated with more advanced disease at presentation and delays in definitive treatment, factors that may affect the timing and utilization of diagnostic imaging for staging and follow-up (Collins et al., 2024; Chen et al., 2023).

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Access-related barriers further contribute to variability in imaging and care delivery. Individuals from historically marginalized populations are more likely to experience delays in referral to specialty care, receive care from lower-volume providers, and encounter communication or health-literacy challenges that may affect adherence to recommended diagnostic and surveillance pathways (Asamoah et al., 2022; Chen et al., 2023). Cumulative exposure to adverse social determinants of health has been shown to prolong time to treatment initiation, with disproportionate effects observed among Black and Hispanic/Latino individuals, potentially increasing the likelihood of advanced diagnostic evaluation rather than earlier risk-appropriate imaging (Collins et al., 2024; Onadeko & Desai, 2025). Awareness of these factors underscores the importance of consistent, guideline-aligned imaging criteria to support equitable diagnostic evaluation across populations.

Oncology Imaging Guidelines

Thyroid Cancer – Suspected/Diagnosis (ONC-6.1)

ON.TC.0006.1.A
v1.0.2027

- See: **Thyroid Nodule (NECK-8.1)** in the Neck Imaging Guidelines for suspected thyroid malignancies.

Oncology Imaging Guidelines

Thyroid Cancer – Initial Work-Up/Staging (ONC-6.2)

ON.TC.006.2.C
v1.0.2027

Criteria

Follicular, Papillary, and Hürthle Cell (Oncocytic) Carcinomas	Medically Necessary Imaging Study
ONE of the following in individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas : • Locally advanced disease or fixation suggested by clinical exam and/or ultrasound • Substernal or bulky disease • Disease precluding full ultrasound examination • Vocal cord paresis • Surgical planning	ONE of the following: • MRI Neck without contrast (CPT® 70540) OR • MRI Neck without and with contrast (CPT® 70543) AND • CT Neck with contrast (CPT® 70491) if contrast study is necessary for complete pre-operative assessment and use of IV contrast will not delay post-operative use of RAI therapy
In individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas: • Extent of thyroid remnant cannot be accurately ascertained from the surgical report, neck ultrasound, or cross-sectional imaging • Unresectable residual disease • To assess for iodine-avid metastatic disease • When the results may alter the decision to treat • Prior to and within 2 weeks (ideally 7 to 10 days) following the administration of RAI therapy	• Whole-Body Thyroid Nuclear scan (CPT® 78018) ◦ CPT® 78020 as an add-on test to evaluate the degree of iodine uptake AND/OR • SPECT (CPT® 78803, or CPT® 78831), OR SPECT/CT Hybrid study (CPT® 78830, or CPT® 78832)

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Follicular, Papillary, and Hürthle Cell (Oncocytic) Carcinomas	Medically Necessary Imaging Study
Skeletal pain in individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas	• Bone scan (CPT® 78306) • Whole-Body Thyroid Nuclear scan (CPT® 78018) ◦ CPT® 78020 as an add-on test to evaluate the degree of iodine uptake AND/OR • SPECT (CPT® 78803, or CPT® 78831), OR SPECT/CT Hybrid study (CPT® 78830, or CPT® 78832)
Suspicious findings on Chest X-ray, US, or substernal extension of mass in individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas	• CT Chest with contrast (CPT® 71260)
All other individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas	• Routine preoperative advanced imaging is not considered medically necessary

Medullary Thyroid Carcinomas	Medically Necessary Imaging Study
ANY of the following in individuals with medullary thyroid carcinomas: • Elevated CEA levels • Calcitonin level greater than 300pg/mL • Positive lymph nodes	ANY or ALL of the following: • CT Neck with contrast (CPT® 70491) • CT Chest with contrast (CPT® 71260) • CT Abdomen with contrast (CPT® 74160) **or** CT Abdomen without and with contrast (CPT® 74170) • MRI Abdomen without and with contrast (CPT® 74183) • Bone scan (CPT® 78306)
Skeletal pain in individuals with medullary thyroid carcinomas	• Bone scan (CPT® 78306)
Inconclusive findings on conventional imaging in individuals with medullary thyroid carcinomas	• ^{68}Gallium-labeled PET/CT (CPT® 78815)

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Anaplastic/Poorly Differentiated Thyroid Carcinomas	Medically Necessary Imaging Study
All individuals with anaplastic/poorly differentiated thyroid carcinomas	ANY or ALL of the following: • CT Neck with contrast (CPT® 70491) or MRI Orbit, Face, Neck without and with contrast (CPT® 70543) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • FDG PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and 76498) • MRI Brain without and with contrast (CPT® 70553)
Skeletal pain in individuals with anaplastic/poorly differentiated thyroid carcinomas	• Bone scan (CPT® 78306)

Background and Supporting Information

Thyroid carcinoma includes a heterogeneous group of malignancies arising from follicular epithelial cells (differentiated carcinomas, poorly differentiated carcinomas, and anaplastic carcinoma) and parafollicular C cells (medullary thyroid carcinoma). Differentiated thyroid carcinomas (papillary, follicular, and Hürthle/oncocytic) account for the majority of cases and generally have favorable prognoses, whereas medullary and anaplastic subtypes demonstrate more aggressive biologic behavior and higher rates of regional and distant metastasis (Chakrabarty et al., 2024; Ringel et al., 2025).

Differentiated thyroid cancers typically retain the ability to concentrate iodine, allowing for functional imaging with radioiodine (RAI) whole body scans to detect residual thyroid tissue and metastatic disease. In contrast, medullary thyroid carcinoma does not demonstrate iodine uptake and requires alternative imaging approaches for staging. Anaplastic thyroid carcinoma is highly aggressive and frequently presents with extensive local invasion and distant metastases at diagnosis, necessitating comprehensive multimodality imaging (Wells et al., 2015; Kushchayev et al., 2019).

Metastatic patterns vary by subtype. Differentiated thyroid cancers most commonly metastasize to lymph nodes and lungs, medullary thyroid carcinoma frequently spreads to lymph nodes, liver, lungs, and bone, and anaplastic carcinoma often involves multiple distant sites, including lung, bone, and brain. These differences in tumor biology inform

risk adapted imaging strategies for initial staging (Kushchayev et al., 2019; Chakrabarty et al., 2024).

Evidence Discussion

Evidence supports selective use of cross-sectional imaging for differentiated thyroid carcinomas when there are clinical or ultrasound features suggesting advanced local disease. CT or MRI of the neck improves delineation of tumor extent, including invasion of adjacent structures and nodal involvement, which is critical for surgical planning. Routine preoperative advanced imaging in low-risk individuals without these features has not shown added benefit and may increase exposure to unnecessary contrast and radiation (Chakrabarty et al., 2024; Ringel et al., 2025).

Whole-body radioiodine (RAI) scanning is an essential component of staging in differentiated thyroid cancer following thyroidectomy or when evaluating residual disease. Evidence demonstrates that RAI imaging is highly sensitive for iodine-avid disease and directly influences decisions regarding adjuvant therapy. The addition of SPECT or SPECT/CT improves anatomic localization and diagnostic accuracy. Consideration of prior iodinated contrast exposure is important, as it may interfere with iodine uptake and reduce the effectiveness of RAI imaging if not appropriately timed (Ringel et al., 2025; Chakrabarty et al., 2024).

Medullary thyroid carcinoma demonstrates a higher propensity for early regional and distant metastases, with reported rates of approximately 35% regional and 13% distant disease at presentation. Elevated calcitonin and CEA levels correlate with tumor burden and metastatic risk, supporting the use of comprehensive imaging that includes CT of the neck, chest, and abdomen, along with evaluation for bone metastases in appropriate clinical scenarios. No single modality reliably detects all disease sites, necessitating multimodality staging in higher-risk patients (Wells et al., 2015; Kushchayev et al., 2019).

Functional imaging with PET-based techniques is reserved for cases with inconclusive conventional imaging or high suspicion of metastatic disease. In medullary thyroid carcinoma, PET imaging has improved sensitivity in patients with elevated tumor markers and may detect disease not visualized on CT or MRI. Restricting PET imaging to selected indications helps avoid false-positive findings and unnecessary interventions while preserving its diagnostic value when results will influence management (Kushchayev et al., 2019).

Anaplastic thyroid carcinoma requires comprehensive staging at diagnosis due to its aggressive nature and high likelihood of distant metastases, which occur in more than 50% of cases. Combined imaging with CT, PET/CT, and brain imaging provides a complete assessment of disease burden, including vascular, airway, and intracranial involvement, and is essential for determining resectability and guiding urgent

multidisciplinary treatment decisions. This intensive imaging approach is justified by the poor prognosis and rapid progression of this disease (Chakrabarty et al., 2024).

Oncology Imaging Guidelines

Thyroid Cancer – Restaging/Recurrence (ONC-6.3)

ON.TC.0006.3.C
v1.0.2027

Criteria

Follicular, Papillary, and Hürthle Cell (Oncocytic) Carcinomas	Medically Necessary Imaging Study
Post-thyroidectomy, if gross residual disease in individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas	ONE of the following: • MRI Neck without contrast (CPT® 70540) • MRI Neck without and with contrast (CPT® 70543) • CT Neck with contrast (CPT® 70491) • In individuals with oncocytic carcinomas, CT Chest (contrast as requested)
Prior to and within 2 weeks (ideally 7 to 10 days) following the administration of Radioactive Iodine therapy in individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas	• Whole-body Thyroid Nuclear Scan (CPT® 78018) • The following may be approved as an add-on test: ◦ CPT® 78020 to evaluate the degree of iodine uptake ◦ SPECT (CPT® 78803, or CPT® 78831) or SPECT/CT Hybrid study (CPT® 78830, or CPT® 78832)

Oncology Imaging Guidelines

Follicular, Papillary, and Hürthle Cell (Oncocytic) Carcinomas	Medically Necessary Imaging Study
ANY of the following in individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas: • Recurrence documented by biopsy • Increasing thyroglobulin level without Thyrogen® stimulation • Thyroglobulin level greater than 2 ng/mL or higher than previous after Thyrogen® stimulation • Anti-thyroglobulin antibody present • Evidence of residual thyroid tissue on ultrasound or physical exam after thyroidectomy or ablation	ALL of the following: • CT Neck with contrast (CPT® 70491) or MRI Neck without and with contrast (CPT® 70543) • CT Chest with contrast (CPT® 71260) • CT with contrast of any symptomatic body area • Whole-body Thyroid Nuclear Scan (CPT® 78018) ◦ As an add-on test: ▪ CPT® 78020 to evaluate the degree of iodine uptake ▪ SPECT (CPT® 78803 or CPT® 78831), or SPECT/CT Hybrid study (CPT® 78830, or CPT® 78832)
Individuals with RAI-refractory residual, recurrent and/or distant metastatic follicular, papillary, and Hürthle cell (oncocytic) carcinomas, prior to starting systemic therapy	In addition to the imaging in the box above: • MRI Brain with contrast (CPT® 70552) or without and with contrast (CPT® 70553) OR • CT Head with contrast (CPT® 70460) or without and with contrast (CPT® 70470)
ANY of the following in individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas: • Rising thyroglobulin level with negative CT scans AND radioiodine scan • Inconclusive findings on conventional imaging (CT scans and radioiodine scan) • Known radioiodine-refractory disease and CT scans are negative or inconclusive	• FDG PET/CT (CPT® 78815)

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Follicular, Papillary, and Hürthle Cell (Oncocytic) Carcinomas	Medically Necessary Imaging Study
Measurable metastatic disease on systemic therapy (no more often than every 2 cycles) in individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas	• CT Chest with contrast (CPT® 71260) • CT with contrast of affected or symptomatic body area

Medullary Thyroid Carcinoma	Medically Necessary Imaging Study
ANY of the following in individuals with medullary thyroid carcinoma: • Elevated CEA levels • Calcitonin level greater than or equal to 150 pg/mL • Signs or symptoms of recurrence	ANY or ALL of the following: • CT Neck with contrast (CPT® 70491) or MRI Neck without and with contrast (CPT® 70543) • CT Chest with contrast (CPT® 71260) • CT Abdomen with contrast (CPT® 74160) **or** CT Abdomen without and with contrast (CPT® 74170) • Bone scan (CPT® 78306)
Inconclusive conventional imaging with calcitonin greater than or equal to 150 pg per mL in individuals with medullary thyroid carcinoma	• ^{68}Gallium-labeled DOTATATE PET/CT (CPT® 78815)
Calcitonin level greater than 500 in individuals with medullary thyroid carcinoma	ONE of the following: • MRI Abdomen without and with contrast (CPT® 74183) • Whole-body MRI (CPT® 76498)

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Anaplastic/Poorly Differentiated Thyroid Carcinoma	Medically Necessary Imaging Study
Measurable metastatic disease on systemic treatment in individuals with anaplastic/poorly differentiated thyroid carcinoma	Any of the following every 2 cycles (usually every 6-8 weeks): • CT Neck with contrast (CPT® 70491) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT of any other involved/symptomatic sites
Signs or symptoms of recurrence in individuals with anaplastic/poorly differentiated thyroid carcinoma	ONE of the following combinations, not both: • CT Neck with contrast (CPT® 70491), CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177) **OR** • FDG PET/CT (CPT® 78815) In addition to one of the above studies: • MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Recurrence and persistent disease in thyroid carcinoma vary significantly by histologic subtype and initial risk stratification. Differentiated thyroid cancers (DTC), including papillary, follicular, and oncocytic carcinomas, typically demonstrate an indolent course but may recur locally, regionally, or at distant sites, sometimes years after initial treatment. Risk of recurrence ranges widely (<1% to >20%) depending on tumor characteristics such as extrathyroidal extension, nodal involvement, vascular invasion, and molecular features (Filetti et al., 2019).

Post-treatment surveillance and detection of recurrence rely on a combination of clinical examination, laboratory testing (thyroglobulin and anti thyroglobulin antibodies), and imaging. Rising thyroglobulin levels, particularly when increasing over time, are strongly suggestive of persistent or recurrent disease even in the absence of structural findings on ultrasound or cross sectional imaging (Filetti et al., 2019; NCCN, 2025).

Radioiodine (RAI) imaging plays a central role in restaging differentiated thyroid cancer due to the iodine avid nature of most tumor cells. Whole body RAI scanning following therapy allows detection of residual or metastatic disease and assessment of iodine avidity, which directly influences further management. However, a subset of tumors

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loses iodine concentrating ability over time, resulting in RAI refractory disease that requires alternative imaging strategies (Filetti et al., 2019).

Medullary thyroid carcinoma (MTC) and anaplastic thyroid carcinoma (ATC) require different restaging approaches due to their biologic behavior. MTC is often associated with biochemical recurrence based on calcitonin and carcinoembryonic antigen levels, with imaging directed by tumor marker elevation and clinical suspicion. ATC is highly aggressive, frequently presenting with widespread disease and requiring comprehensive imaging to evaluate the full extent of recurrence or progression (Filetti et al., 2019; NCCN, 2025).

Evidence Discussion

For differentiated thyroid carcinomas, imaging after thyroidectomy is guided by biochemical and clinical indicators of recurrence. When gross residual disease is present, cross-sectional imaging with contrast-enhanced CT or MRI provides essential delineation of local disease extent and guides further treatment planning. Following RAI therapy, whole-body radioiodine scanning performed within approximately 1–2 weeks is supported to evaluate treatment response and document iodine uptake, which is critical in determining whether additional RAI therapy will be effective (Filetti et al., 2019; NCCN, 2025).

In cases of suspected recurrence based on biopsy, rising thyroglobulin levels, or suspicious clinical or ultrasound findings, combined anatomic and functional imaging is considered medically necessary. CT or MRI of the neck and CT of the chest are used to detect locoregional and pulmonary metastases, while whole-body RAI scanning evaluates iodine-avid disease. This multimodality approach ensures comprehensive restaging and directly informs decisions regarding surgery, additional RAI therapy, or systemic treatment (Filetti et al., 2019).

FDG PET/CT is reserved for patients with rising thyroglobulin and negative conventional imaging or known RAI-refractory disease. Evidence demonstrates high sensitivity (approximately 94%) and specificity (approximately 80%–84%) for detection of metabolically active disease in this setting, with FDG uptake correlating with tumor aggressiveness and poor response to RAI therapy. Restricting PET/CT to these scenarios minimizes false-positive findings and unnecessary interventions while preserving its clinical value (Filetti et al., 2019).

For medullary thyroid carcinoma, imaging is guided by biochemical markers, particularly calcitonin and CEA levels. Elevated or rising levels, especially above clinically significant thresholds, are associated with increased likelihood of regional and distant metastases, supporting the use of CT-based imaging and bone scans to evaluate disease burden. Advanced functional imaging using somatostatin receptor–based PET techniques is considered medically necessary when conventional imaging is inconclusive, given improved sensitivity in detecting metastatic disease (Filetti et al., 2019).

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Anaplastic thyroid carcinoma requires aggressive restaging due to its rapid progression and high incidence of distant metastases at recurrence. Comprehensive imaging, including CT, PET/CT, and brain MRI, is considered medically necessary to fully characterize disease extent, guide systemic therapy decisions, and assess response during treatment. Frequent interval imaging during systemic therapy allows timely identification of progression while balancing the need to monitor disease with avoidance of excessive imaging (Filetti et al., 2019; NCCN, 2025).

Oncology Imaging Guidelines

Thyroid Cancer – Surveillance/Follow-up (ONC-6.4)

ON.TC.0006.4.A
v1.0.2027

Criteria

Follicular, Papillary, and Hürthle Cell (Oncocytic) Carcinomas	Medically Necessary Imaging Study
Individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas being monitored on active surveillance	• Neck ultrasound (CPT® 76536) every 6 months for 2 years, and then annually thereafter
All other individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas post-treatment	• Neck ultrasound (CPT® 76536) once at 6-12 months post-treatment, and then annually thereafter
For individuals with follicular, papillary, and Hürthle cell (oncocytic) carcinomas with ANY of the following: • Node positive disease • RAI-avid metastases	• Whole-body Thyroid Nuclear Scan annually (CPT® 78018) ◦ CPT® 78020 as an add-on test to evaluate the degree of iodine uptake AND/OR • SPECT (CPT® 78803, or CPT® 78831), OR SPECT/CT Hybrid study (CPT® 78830, or CPT® 78832)

Medullary Carcinomas	Medically Necessary Imaging Study
All individuals with medullary carcinomas	• CEA and calcitonin are required for monitoring medullary carcinomas • Routine surveillance imaging is not considered medically necessary

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Anaplastic/Poorly Differentiated Thyroid Carcinomas	Medically Necessary Imaging Study
All individuals with anaplastic/ poorly differentiated thyroid carcinomas	Every 3 months for 2 years: • CT Neck with contrast (CPT® 70491) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Surveillance strategies in thyroid cancer are guided by histologic subtype, initial stage, and risk of recurrence. Differentiated thyroid carcinomas (papillary, follicular, and oncocytic) are generally associated with favorable outcomes but demonstrate variable recurrence risk depending on tumor size, nodal involvement, extrathyroidal extension, and molecular characteristics. Long term monitoring is therefore risk adapted and integrates clinical assessment, laboratory findings, and selective imaging (Chakrabarty et al., 2024).

Evidence Discussion

Evidence supports ultrasound-based surveillance as the primary imaging modality for differentiated thyroid carcinomas due to its high sensitivity for detecting local recurrence and lack of radiation exposure. Studies summarized in clinical guidelines demonstrate that most clinically relevant recurrences occur in the neck and can be effectively identified with ultrasound in conjunction with serum thyroglobulin monitoring. Limiting imaging to ultrasound in low-risk individuals reduces unnecessary radiation exposure and avoids false-positive findings associated with routine cross-sectional imaging (Chakrabarty et al., 2024; NCCN, 2025).

In patients with higher-risk features, including node-positive disease or known RAI-avid metastases, periodic whole-body radioiodine scanning is supported to detect residual or recurrent iodine-avid disease. Evidence indicates that these scans can identify occult metastases and inform decisions regarding additional RAI therapy. The addition of SPECT or SPECT/CT improves lesion localization and diagnostic confidence, particularly in anatomically complex regions (Chakrabarty et al., 2024).

For medullary thyroid carcinoma, surveillance imaging is not routinely supported in the absence of clinical or biochemical evidence of recurrence. Serum calcitonin and CEA levels are highly sensitive markers of disease activity and are used to guide further evaluation. Imaging is reserved for cases with rising markers or clinical suspicion,

thereby avoiding unnecessary imaging in asymptomatic individuals while maintaining sensitivity for clinically meaningful disease (NCCN, 2025).

Anaplastic and poorly differentiated thyroid carcinomas carry a high risk of early recurrence and rapid disease progression, with most relapses occurring within the first two years after diagnosis. Frequent cross-sectional imaging, including CT and MRI, is supported in this population to detect progression and guide treatment decisions in a timely manner. This intensive surveillance strategy reflects the aggressive biology of these tumors and balances the need for early detection against the risks of repeated imaging, which are justified given the poor prognosis and high likelihood of recurrence (Chakrabarty et al., 2024; NCCN, 2025).

Oncology Imaging Guidelines

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v1.0.2027

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Small Cell Lung Cancer (ONC-7)

Guideline Page

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Oncology Imaging Guidelines

Small Cell Lung Cancer – General Considerations (ONC-7.0)

ON.SL.0007.0.A
v1.0.2027

Criteria

- Combined histologies of small and non-small cell are considered small cell lung cancer (SCLC). Use this guideline for imaging recommendations for small and large cell high-grade (poorly differentiated) neuroendocrine tumors of the lung.
- Imaging is presently guided by traditional staging of limited or extensive disease.
  - Extensive stage is either metastatic disease or an extent which cannot be encompassed by a single radiotherapy portal.
  - Limited staging is confined to one side of the chest.
- Individuals treated curatively for SCLC are at increased risk for developing a second lung cancer. If new lung nodule is seen on imaging without any evidence of other systemic disease, follow **Lung Metastases (ONC-31.1)** for work-up of nodule.
- For carcinoid (low-grade neuroendocrine tumors) of the lung, see: **Neuroendocrine Cancers and Adrenal Tumors (ONC-15)**.

Background and Supporting Information

Small cell lung cancer (SCLC) is a high grade, poorly differentiated neuroendocrine carcinoma characterized by rapid growth, early metastatic spread, and strong association with tobacco use. It accounts for approximately 13% of lung cancers and demonstrates aggressive clinical behavior, with most patients presenting with advanced disease at diagnosis (NCCN, 2026; NCI, 2024).

The biology of SCLC is notable for early hematogenous dissemination, with common metastatic sites including the brain, liver, adrenal glands, bone, and contralateral lung. Brain metastases are particularly common, and a substantial proportion of patients may have asymptomatic central nervous system involvement at diagnosis, underscoring the importance of appropriate imaging strategies (NCCN, 2026).

Evidence Discussion

Evidence supports imaging strategies in SCLC that are tailored to its highly aggressive biology and simplified staging system. Because SCLC is characterized by rapid growth and early widespread metastases, imaging plays a critical role in determining whether disease is limited or extensive, which directly influences treatment planning and prognosis (NCCN, 2026; NCI, 2024).

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The use of a limited versus extensive staging framework allows clinicians to align imaging intensity with disease burden. Limited stage disease may be encompassed within a single radiation field, while extensive stage disease requires systemic therapy due to disseminated involvement. This dichotomous approach simplifies clinical decision making and avoids unnecessary imaging beyond what is required to establish disease extent (NCCN, 2026).

SCLC's propensity for early metastasis, particularly to the brain and distant organs, supports the use of comprehensive imaging when clinically indicated. However, routine screening modalities, such as low dose CT, are less effective for detecting SCLC at an early stage because of its rapid doubling time and tendency to progress between screening intervals. This limits the benefit of screening based imaging for SCLC compared with other lung cancer subtypes (NCCN, 2026; USPSTF, 2021).

Additionally, individuals treated for SCLC remain at increased risk for developing second primary lung cancers, particularly due to shared risk factors such as smoking. Imaging strategies must therefore balance detection of recurrence or new primary tumors with avoidance of unnecessary imaging and associated harms, including radiation exposure and false positive findings. A risk adapted approach ensures that imaging is used when it is most likely to influence management while minimizing unnecessary interventions (NCCN, 2026; NCI, 2024).

Health Equity Considerations

Small cell lung cancer (SCLC) is characterized by aggressive tumor biology, rapid progression, and a strong association with tobacco exposure, factors that limit opportunities for early detection and contribute to poor overall outcomes. Population-level data demonstrate that SCLC is more frequently diagnosed at advanced or metastatic stages compared with non–small cell lung cancer, with over two-thirds of cases presenting with distant disease at diagnosis (Monestime et al., 2023). Structural inequities compound this biologic aggressiveness. Individuals from racial and ethnic minority groups, lower socioeconomic strata, and rural communities experience higher smoking prevalence, delayed access to diagnostic evaluation, and lower likelihood of timely treatment initiation, resulting in worse survival (Bade et al., 2025; American Lung Association, 2025). Although lung cancer screening has improved stage distribution for NSCLC, current screening paradigms are less effective for SCLC due to its rapid growth kinetics, limiting the potential mitigating effect of population-based screening on equity gaps (USPSTF, 2021; Monestime et al., 2023).

Disparities also extend to imaging utilization and treatment pathways following diagnosis. Black individuals and individuals with public or no insurance are less likely to receive guideline-concordant systemic therapy, prophylactic cranial irradiation, or consolidative thoracic radiation for extensive-stage SCLC, even when clinically appropriate (Bade et al., 2025; Monestime et al., 2023). Geographic

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barriers, transportation limitations, and care fragmentation further delay staging and response-assessment imaging in underserved populations, increasing the risk of missed opportunities to guide timely management decisions (Shehata et al., 2025). Awareness of these inequities highlights the importance of consistent, evidence-based imaging criteria for diagnosis, staging, and surveillance in SCLC, supporting equitable clinical decision-making across diverse populations regardless of social or structural barriers.

Oncology Imaging Guidelines

Small Cell Lung Cancer – Suspected/ Diagnosis (ONC-7.1)

ON.SL.0007.1.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
• Abnormal chest x-ray or clinical suspicion for small cell lung cancer remains high despite a normal chest x-ray in symptomatic individual	• CT Chest without contrast (CPT® 71250) **or** • CT Chest with contrast (CPT® 71260)
• Pulmonary nodule less than 8mm in size noted on CT Chest in individuals with suspected small cell lung cancer	• See: **Incidental Pulmonary Nodules Detected on CT Images (CH-16.2)** in the Chest Imaging Guidelines
• Pulmonary nodule 8mm (0.8cm) to 30mm (3cm) seen on dedicated chest imaging in individuals with suspected small cell lung cancer (See **Solitary Pulmonary Nodule - Imaging (CH-16.1)**)	• PET/CT (CPT® 78815) • PET is Positive: Qualifies as initial staging PET/CT

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Indication	Medically Necessary Imaging Study
• Pulmonary mass 31mm (3.1cm) or greater seen on CT or MRI in individuals with suspected small cell lung cancer	• PET/CT (CPT® 78815) prior to biopsy if ONE OR MORE of the following applies: ◦ Definitive treatment with resection or radiation will be utilized instead of biopsy if PET confirms limited disease ◦ Multiple possible biopsy options are present within the chest and PET findings will be used to determine the most favorable biopsy site • Biopsy is considered medically necessary prior to PET imaging for all other indications in pulmonary masses greater than or equal to 31mm (3.1cm) in size
• Mediastinal/Hilar Mass in individuals with suspected small cell lung cancer	See: **Lymphadenopathy (CH-2)** in the Chest Imaging Guidelines
• Paraneoplastic syndrome suspected	See: **Paraneoplastic Syndromes (ONC-30.3)**

Background and Supporting Information

Small cell lung cancer (SCLC) is an aggressive neuroendocrine malignancy characterized by rapid tumor growth, high mitotic rate, and early metastatic dissemination. It is strongly associated with tobacco exposure and often presents with advanced disease at the time of diagnosis due to its rapid progression and early involvement of distant sites (NCCN, 2026; NCI, 2024).

Individuals commonly present with respiratory symptoms such as cough, dyspnea, hemoptysis, or systemic symptoms including weight loss and fatigue. Paraneoplastic syndromes are also frequently associated with SCLC due to ectopic hormone production. Initial clinical suspicion often arises from abnormal chest imaging, including chest radiography or CT findings, which then prompt further diagnostic evaluation (NCCN, 2026).

SCLC frequently presents as a centrally located mass with mediastinal or hilar lymphadenopathy. Rapid doubling time and early dissemination to organs such as the brain, liver, bone, and adrenal glands are hallmarks of the disease. Brain metastases may be present at diagnosis or develop early in the disease course, often before onset of neurologic symptoms (Gaebe et al., 2024).

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Definitive diagnosis requires histologic confirmation, typically obtained via biopsy of the primary lung lesion or metastatic site. Imaging plays a key role in identifying suspicious lesions, guiding biopsy site selection, and determining the most appropriate initial diagnostic pathway. The choice and sequence of imaging modalities are therefore determined by lesion size, accessibility, and clinical context (NCCN, 2026).

Evidence Discussion

Evidence supports CT imaging of the chest as the initial diagnostic modality in individuals with suspected small cell lung cancer based on abnormal chest radiography or persistent clinical suspicion. CT provides detailed anatomic characterization of pulmonary lesions, mediastinal involvement, and potential metastatic sites within the thorax, allowing for accurate identification of lesions requiring biopsy. Both contrast and non contrast CT may be appropriate depending on clinical circumstances, with contrast enhancing evaluation of mediastinal structures (NCCN, 2026).

For pulmonary nodules measuring 8mm or greater, FDG-PET/CT demonstrates improved sensitivity and specificity for detecting metabolically active malignancy and is supported to further characterize indeterminate lesions. A positive PET/CT in this setting can serve as the initial staging study, reducing the need for redundant imaging. However, PET is not recommended for very small nodules due to reduced sensitivity and increased likelihood of false negative results (NCI, 2024).

In larger pulmonary masses, particularly those measuring greater than 3cm, tissue diagnosis remains the priority. PET/CT may be used selectively prior to biopsy when results are expected to influence clinical management, such as identifying the most accessible or highest yield biopsy site or when definitive local therapy is being considered without biopsy. This selective approach minimizes unnecessary delays in diagnosis while optimizing procedural safety and diagnostic yield (NCCN, 2026).

FDG remains the radiotracer of choice for PET imaging in SCLC due to its high uptake in rapidly proliferating tumors. In contrast, somatostatin receptor–based imaging techniques have uncertain sensitivity and specificity in SCLC and are not considered medically necessary for routine diagnostic evaluation. This distinction is important given the neuroendocrine features of SCLC, which do not reliably translate to consistent uptake on somatostatin receptor imaging studies (NCI, 2024).

Overall, limiting advanced imaging to clinically appropriate scenarios ensures accurate diagnosis while reducing unnecessary radiation exposure, false positive findings, and downstream procedures. Imaging strategies in suspected SCLC are therefore guided by lesion characteristics, clinical suspicion, and the need to efficiently establish a tissue diagnosis that directs treatment planning (NCCN, 2026).

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Small Cell Lung Cancer – Initial Workup/ Staging (ONC-7.2)

ON.SL.0007.2.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Initial staging in individuals with small cell lung cancer	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Brain without and with contrast (CPT® 70553) • Bone scan (CPT® 78306), if PET/CT not being done or not available
• To confirm the extent of disease in individuals with small cell lung cancer when initial CT Chest/Abdomen/ Pelvis and MRI Brain indicate limited stage disease (confined to one side of the chest) • To evaluate inconclusive findings on conventional imaging in individuals with small cell lung cancer	• PET/CT (CPT® 78815)
• Inconclusive bone findings on PET/CT or bone scan in individuals with small cell lung cancer	• MRI without and with contrast of the involved body site

Background and Supporting Information

Small cell lung cancer (SCLC) is an aggressive malignancy with rapid growth kinetics and a high propensity for early hematogenous dissemination. At diagnosis, the majority of patients present with metastatic disease, with approximately two-thirds having distant

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involvement and a significant subset demonstrating central nervous system metastases (NCCN, 2026; Gaebe et al., 2024).

Staging of SCLC is essential to distinguish limited stage disease, which is confined to one hemithorax and may be treated with curative intent, from extensive stage disease, which includes distant metastases and requires systemic therapy. Comprehensive imaging is required to accurately determine disease burden and to guide therapeutic planning (NCCN, 2026).

Evidence Discussion

The use of contrast-enhanced CT of the chest, abdomen, and pelvis, along with MRI of the brain, is supported for initial staging in small cell lung cancer due to the high prevalence of metastatic disease at presentation. Evidence demonstrates that most patients have disseminated disease at diagnosis, and a clinically meaningful proportion harbor central nervous system metastases, often asymptomatic. Comprehensive anatomic imaging therefore improves detection of both thoracic and extrathoracic disease and is critical for accurate staging and treatment selection (NCCN, 2026; Gaebe et al., 2024).

FDG-PET/CT has demonstrated value in refining staging accuracy when conventional imaging suggests limited-stage disease or yields inconclusive findings. Studies indicate that PET/CT can result in stage migration in a substantial proportion of patients, identifying occult metastatic disease not detected on CT alone. This prevents inappropriate assignment of limited-stage disease and reduces the risk of overtreatment with curative intent therapies in patients with unrecognized extensive disease (NCCN, 2026).

However, PET/CT is not universally required in all patients. When prior PET/CT has already been performed during initial evaluation or when conventional imaging clearly demonstrates extensive-stage disease, additional PET/CT imaging does not meaningfully alter management and may expose patients to unnecessary radiation and cost. This supports a selective approach to PET/CT use based on clinical context and prior imaging (NCCN, 2026).

Evaluation of osseous metastatic disease is also important, as bone involvement is common in SCLC. Bone scan or PET/CT can identify skeletal metastases, and targeted MRI may be used to clarify equivocal findings. This tiered approach balances sensitivity for detecting metastatic disease with avoidance of unnecessary imaging, ensuring that additional studies are reserved for situations where results will influence staging accuracy or clinical management (NCCN, 2026; NCI, 2024).

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Small Cell Lung Cancer – Restaging/ Recurrence (ONC-7.3)

ON.SL.0007.3.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Treatment response in individuals with small cell lung cancer treated with sequential chemotherapy-radiation or chemotherapy alone* *For individuals receiving systemic therapy and concurrent radiation therapy, response assessment is recommended only after completion of initial therapy (see box below).	After every 2 cycles, ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Brain without and with contrast (CPT® 70553) for measurable brain metastases being treated with systemic therapy • Bone scan (CPT® 78306) • PET is not considered medically necessary for evaluation of treatment response in SCLC but can be considered on a case-by-case basis.
Following completion of planned treatment in individuals with small cell lung cnacer: • Chemoradiation • Adjuvant chemotherapy • Radiation	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Brain without and with contrast (CPT® 70553) for measurable brain metastases being treated with systemic therapy • Bone scan (CPT® 78306)

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Indication	Medically Necessary Imaging Study
Restaging (suspected recurrence) in individuals with small cell lung cnacer	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Brain without and with contrast (CPT® 70553) • Bone scan (CPT® 78306) • PET is not considered medically necessary for evaluation of recurrent SCLC but can be considered on a case-by-case basis.
For response assessment following primary treatment in individuals with small cell lung cnacer	• MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Small cell lung cancer (SCLC) is characterized by rapid proliferation, early response to therapy, and high rates of relapse. Although many patients initially respond to chemotherapy and radiation therapy, recurrent disease is common and typically occurs within the first 1–2 years following treatment. The pattern of relapse may involve the thorax, distant organs, or the central nervous system, reflecting the systemic nature of the disease (NCCN, 2026; NCI, 2024).

Evidence Discussion

Evidence supports the use of serial contrast-enhanced CT of the chest, abdomen, and pelvis for response assessment in SCLC during active therapy. Imaging after every two cycles of chemotherapy allows timely evaluation of tumor response or progression, enabling modification of treatment when necessary. This interval balances the need for close monitoring of a rapidly evolving disease with avoidance of excessive imaging (NCCN, 2026; NCI, 2024).

Brain metastases are particularly important in SCLC surveillance because they may be present without neurologic symptoms and can significantly influence management decisions. MRI of the brain is supported when there is known or suspected central nervous system involvement or when evaluating response of brain metastases to systemic therapy. Additionally, brain imaging at completion of initial therapy is supported in patients being considered for prophylactic cranial irradiation, as a proportion of

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patients may harbor asymptomatic metastases that would alter management and avoid unnecessary exposure to neurotoxic radiation (NCCN, 2026).

Following completion of treatment, cross-sectional imaging continues to play a central role in detecting residual or recurrent disease. CT imaging of the chest, abdomen, and pelvis, along with brain MRI and bone imaging when indicated, allows comprehensive reassessment of disease burden. This approach is supported by the high likelihood of relapse and the potential for recurrence in multiple organ systems (NCCN, 2026; NCI, 2024).

FDG-PET/CT has not demonstrated consistent benefit for routine response assessment or surveillance in SCLC. While emerging evidence suggests a potential role in selected scenarios, particularly in evaluating equivocal findings or osseous disease, current guidelines do not support its routine use due to variable impact on management and potential for false-positive results. Restricting PET/CT to case-by-case use aligns with evidence-based practice and minimizes unnecessary imaging and downstream interventions (NCCN, 2026).

Oncology Imaging Guidelines

Small Cell Lung Cancer – Surveillance/ Follow-up (ONC-7.4)

ON.PC.0007.4.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with small cell lung cancer	Every 2-6 months for two years, then no more frequently than every 6 months thereafter: • CT Chest without (CPT® 71250) or CT Chest with (CPT® 71260) contrast • CT Abdomen and Pelvis with contrast (CPT® 74177)
Screening for brain metastases in individuals with small cell lung cancer, regardless of PCI status	• MRI Brain without and with contrast (CPT® 70553) every 3-4 months for 1 year and then every 6 months in year 2, subsequently only for signs and symptoms of recurrence
Surveillance of known and/ or treated brain metastases in individuals with small cell lung cancer	• See: **Brain Metastases (ONC-31.3)**
New lung nodule(s) in individuals with small cell lung cancer	• See: **Lung Metastases (ONC-31.1)**

Background and Supporting Information

Small cell lung cancer (SCLC) demonstrates a high rate of relapse despite initial responsiveness to therapy. Most recurrences occur within the first two years following treatment, although late recurrences and second primary lung cancers may also develop. Surveillance strategies are therefore designed to detect recurrence early while balancing the risks of frequent imaging (NCCN, 2026; NCI, 2024).

Patterns of recurrence commonly involve both locoregional and distant sites, with frequent metastases to the liver, adrenal glands, bone, and brain. Central nervous system involvement is particularly common in SCLC and may occur even in patients without neurologic symptoms, necessitating consideration of routine brain imaging in follow up (NCCN, 2026; Gaebe et al., 2024).

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Evidence Discussion

Evidence supports routine surveillance with contrast-enhanced CT of the chest, abdomen, and pelvis due to the high likelihood of recurrence and the propensity of SCLC to involve multiple organ systems. CT imaging provides reliable detection of thoracic recurrence and distant metastases and is favored over alternative modalities such as MRI of the chest, which demonstrates lower sensitivity for pulmonary lesions. Tailored surveillance intervals reflect the natural history of SCLC, with more frequent imaging during the first two years when recurrence risk is highest (NCCN, 2026; NCI, 2024).

Routine surveillance of the brain with MRI is supported regardless of prior prophylactic cranial irradiation status due to the high incidence of brain metastases in SCLC, reported in up to 30% of patients. MRI provides superior sensitivity and specificity for detection of intracranial disease compared with CT and allows earlier intervention before development of neurologic deficits. Early detection is particularly important given the clinical impact of brain metastases on prognosis and quality of life (NCCN, 2026; Gaebe et al., 2024).

PET/CT is not routinely supported for surveillance due to its limited incremental benefit in this setting and its association with increased radiation exposure, false-positive findings, and higher cost. Limiting PET/CT to select cases where conventional imaging is inconclusive helps avoid unnecessary downstream testing and supports efficient, evidence-based imaging utilization while maintaining diagnostic accuracy for clinically significant recurrence (NCCN, 2026; NCI, 2024).

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Non-Small Cell Lung Cancer (ONC-8)

Guideline Page

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Non-Small Cell Lung Cancer – General Considerations (ONC-8.0)

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Criteria

- See: **Bronchopulmonary or Thymic Carcinoid – Initial Staging (ONC-15.6)** for evaluation of low-grade neuroendocrine tumors (carcinoid) of the lung.
- See: **Small Cell Lung Cancer (ONC-7)** for evaluation of high-grade small cell and large cell neuroendocrine tumors of the lung.
- PET/CT is considered medically necessary to confirm solitary focus of extra-pulmonary metastatic disease (i.e., brain or adrenal) if the individual is being considered for an aggressive treatment for oligometastatic disease.

Background and Supporting Information

Non small cell lung cancer (NSCLC) represents the majority of lung cancers and includes several histologic subtypes, most commonly adenocarcinoma, squamous cell carcinoma, adenosquamous carcinoma, and large cell carcinoma. These tumors are characterized by distinct morphologic and molecular features that guide diagnosis, staging, and treatment selection (NCCN, 2026).

NSCLC is a biologically heterogeneous disease that may range from early stage, localized tumors amenable to surgical resection to advanced metastatic disease requiring systemic therapy. Accurate staging is critical, as treatment strategies and prognosis vary significantly by disease extent. The tumor, node, metastasis (TNM) classification system is used to stratify disease and guide management decisions (NCCN, 2026).

Metastatic spread in NSCLC may involve intrathoracic lymph nodes, contralateral lung, pleura, brain, adrenal glands, bone, and other distant sites. The concept of oligometastatic disease, characterized by a limited number of metastatic lesions, has emerged as a clinically distinct subset in which aggressive local therapy to both primary and metastatic sites may provide benefit in selected individuals (NCCN, 2026).

Diagnostic evaluation and treatment planning for NSCLC require a multidisciplinary approach involving thoracic radiology, pulmonology, surgery, medical oncology, and radiation oncology. Imaging plays a central role in identifying disease extent, guiding biopsy, and determining candidacy for surgical or other local therapies, particularly in patients with potentially limited metastatic disease (NCCN, 2026).

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Evidence Discussion

The use of PET/CT in NSCLC is supported as a problem-solving and staging tool, particularly in patients with suspected limited metastatic disease who are being considered for aggressive local therapy. Evidence demonstrates that FDG PET/CT improves detection of occult metastatic disease compared with conventional imaging and can alter staging and management decisions, especially in identifying or confirming extra pulmonary metastatic sites such as adrenal or distant lesions (NCCN, 2026).

In the context of oligometastatic disease, accurate confirmation of a solitary metastatic focus is critical, as treatment strategies may shift toward curative intent local therapy rather than palliative systemic management. NCCN guidance supports the need for confirmation of suspected metastatic lesions, often requiring additional imaging or tissue sampling, to ensure appropriate patient selection for aggressive interventions such as surgery or stereotactic ablative radiotherapy (NCCN, 2026).

FDG PET/CT provides functional information regarding tumor metabolism, which complements anatomic imaging. However, its use must be interpreted cautiously due to known limitations, including false positive findings from inflammatory or infectious processes and false negative results in lesions with low metabolic activity or small size. For this reason, positive PET findings, particularly in mediastinal nodes or distant sites, often require pathologic or additional radiologic confirmation before treatment decisions are finalized (NCCN, 2026).

Restricting PET/CT use to clinically relevant scenarios such as confirming solitary metastatic disease in patients eligible for definitive therapy balances its diagnostic benefits against potential harms, including unnecessary radiation exposure, false positive findings, and downstream procedures. This selective, indication driven approach ensures that PET/CT is utilized when it is most likely to impact management and improve outcomes in patients with NSCLC (NCCN, 2026).

Health Equity Considerations

Non-small cell lung cancer (NSCLC) accounts for the majority of lung cancer diagnoses and demonstrates substantial disparities across the diagnostic and treatment continuum. Racial and ethnic minority populations, particularly Black individuals, are more likely to be diagnosed at younger ages and with more advanced disease compared with White individuals, even after accounting for smoking exposure, suggesting the influence of structural, environmental, and health system factors (American Lung Association, 2025; Odera et al., 2022). Disparities in lung cancer screening eligibility and uptake contribute to these patterns; current low-dose CT screening criteria, while expanded in 2021, continue to under-identify individuals at highest risk among socioeconomically disadvantaged and minority populations, resulting in fewer early-stage diagnoses amenable to curative treatment (USPSTF, 2021; Monestime et al., 2023). Variability

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in access to diagnostic imaging and timely staging further exacerbates inequities in treatment planning and outcomes (Shehata et al., 2025).

Following diagnosis, inequities persist in imaging utilization, molecular testing, and receipt of guideline-concordant care. Black, Hispanic/Latino, uninsured, and Medicaid-insured individuals are less likely to receive comprehensive staging evaluations, positron emission tomography, and molecular or genomic testing that informs targeted therapy selection in NSCLC (Shehata et al., 2025; Odera et al., 2022). These gaps are associated with lower rates of curative surgery, reduced access to targeted and immunotherapies, and worse survival outcomes, despite evidence that patients derive similar benefit when treated equitably (American Lung Association, 2025; Monestime et al., 2023). Geographic barriers, including rural residence and limited proximity to high-volume cancer centers, further affect access to advanced imaging and follow-up surveillance. Recognition of these structural inequities underscores the importance of standardized, evidence-based imaging criteria in NSCLC to support equitable staging, treatment assessment, and surveillance across diverse patient populations irrespective of social or economic context.

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Non-Small Cell Lung Cancer – Asymptomatic Screening (ONC-8.1)

ON.NL.0008.1.A

v1.0.2027

- See: **Lung Cancer Screening (CH-33)** in the Chest Imaging Guidelines for criteria for Low-dose CT Chest for lung cancer screening.

Oncology Imaging Guidelines

Non-Small Cell Lung Cancer – Suspected/Diagnosis (ONC-8.2)

ON.NL.0008.2.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Abnormal chest x-ray or clinical suspicion for non-small cell lung cancer remains high despite a normal chest x-ray in symptomatic individual	• CT Chest without contrast (CPT® 71250) **or** • CT Chest with contrast (CPT® 71260)
Pulmonary nodule less than 8mm in size noted on CT Chest	• See: **Incidental Pulmonary Nodules Detected on CT Images (CH-16.2)** in the Chest Imaging Guidelines
Pulmonary nodule 8mm (0.8cm) to 30mm (3cm) seen on dedicated chest imaging (See **Solitary Pulmonary Nodule - Imaging (CH-16.1)**)	• PET/CT (CPT® 78815) • If PET is Positive: Qualifies as initial staging PET/CT
Pulmonary mass 31mm (3.1cm) or greater seen on CT or MRI	• PET/CT (CPT® 78815) prior to biopsy if ONE or MORE of the following applies: ◦ Definitive treatment with resection or radiation will be utilized instead of biopsy if PET confirms limited disease ◦ Multiple possible biopsy options are present within the chest and PET findings will be used to determine the most favorable biopsy site • Biopsy is indicated prior to PET imaging for all other indications in pulmonary masses ≥31mm (3.1cm) in size
Mediastinal/Hilar Lymphadenopathy	See: **Mediastinal Lymphadenopathy (CH-2.3)** in the Chest Imaging Guidelines

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Indication	Medically Necessary Imaging Study
Mediastinal/Hilar Mass	See: **Mediastinal Mass (CH-20)** in the Chest Imaging Guidelines
Paraneoplastic syndrome suspected	See: **Paraneoplastic Syndromes (ONC-30.3)**

Background and Supporting Information

Non-small cell lung cancer (NSCLC) encompasses multiple histologic subtypes and typically presents as a pulmonary nodule or mass identified on chest imaging. Pulmonary nodules are common and may represent benign etiologies such as granulomatous disease, intrapulmonary lymph nodes, or infection; however, a subset represents early lung cancer, necessitating structured diagnostic evaluation (NCCN, 2026; MacMahon et al., 2017).

Risk stratification in suspected NSCLC is based on clinical and imaging features, including patient age, smoking history, nodule size, morphology, and location. Nodule size is one of the most important predictors of malignancy risk; smaller nodules have a low probability of cancer, whereas larger nodules and masses demonstrate progressively higher risk (MacMahon et al., 2017).

Evidence Discussion

CT imaging of the chest is the initial diagnostic modality in individuals with abnormal chest radiography or persistent clinical suspicion of lung cancer. CT provides high-resolution anatomic detail that allows for detection and characterization of pulmonary nodules, assessment of morphology, and identification of associated findings. Evidence demonstrates that CT is far more sensitive than chest radiography for detecting small nodules, many of which are not visible on plain films, ensuring early and accurate identification of suspicious lesions (MacMahon et al., 2017).

The distinction between small pulmonary nodules and larger lesions is clinically significant. Nodules less than 8mm carry a low probability of malignancy, often less than 1% in low-risk patients, and are typically managed with surveillance strategies rather than immediate advanced imaging or invasive procedures. In contrast, nodules 8mm or greater demonstrate increasing malignancy risk and warrant further evaluation, including PET/CT or tissue sampling, depending on clinical context (MacMahon et al., 2017).

FDG PET/CT is supported in the evaluation of nodules great than or equal to 8mm because it provides metabolic characterization that complements CT morphology. However, PET/CT has known limitations, including false-positive results caused by infection or inflammation and reduced sensitivity in small or low-metabolic lesions.

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Despite these limitations, PET/CT can meaningfully influence management by identifying metabolically active disease and, when positive, may serve as the initial staging study (NCCN, 2026).

For lesions measuring greater than 3cm, which are considered masses, tissue diagnosis is generally preferred over additional imaging due to the high likelihood of malignancy. Evidence indicates that reliance on imaging alone may delay definitive diagnosis. However, PET/CT may be selectively used prior to biopsy when results will influence management, such as confirming limited disease for definitive therapy or identifying the optimal biopsy site among multiple candidates. This selective approach improves procedural safety and efficiency while avoiding unnecessary imaging and interventions (NCCN, 2026).

Oncology Imaging Guidelines

Non-Small Cell Lung Cancer – Initial Work-Up/Staging (ONC-8.3)

ON.NL.0008.3.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with non-small cell lung cancer	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen with contrast (CPT® 74160) ◦ CT Abdomen can be omitted if CT Chest report clearly documents upper abdomen through level of adrenals • PET/CT (CPT® 78815) (if not already completed prior to histological diagnosis) • Bone scan (CPT® 78306, if PET/CT not being done)
Stage IB-IV non-small cell lung cancer	• MRI Brain without and with contrast (CPT® 70553) ◦ If MRI Brain is contraindicated or not available, CT Head with contrast (CPT® 70460) or CT Head without and with contrast (CPT® 70470)
Superior sulcus (Pancoast) tumor suspected in individuals with non-small cell lung cancer	ANY or ALL of the following: • MRI Chest without and with contrast (CPT® 71552) • MRI Cervical Spine without and with contrast (CPT® 72156) • MRI Thoracic Spine without and with contrast (CPT® 72157)

Background and Supporting Information

Non-small cell lung cancer (NSCLC) is staged using the TNM classification system, which defines tumor extent, nodal involvement, and distant metastatic disease. Accurate initial staging is essential because treatment selection and prognosis vary significantly

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by stage, and curative intent therapies are reserved for individuals without unresectable locoregional or distant metastases (NCCN, 2026).

NSCLC most commonly metastasizes to the liver, adrenal glands, brain, and bone. Cross sectional imaging of the chest and upper abdomen is therefore a foundational component of initial staging, as thoracic and upper abdominal disease burden directly impacts operability and treatment planning. Pelvic metastases are uncommon in the absence of symptoms and are not routinely evaluated during initial staging (NCCN, 2026).

Central nervous system involvement may be present at diagnosis, particularly in individuals with stage II–IV disease, and is frequently asymptomatic. Brain imaging is therefore incorporated into staging algorithms to prevent under staging and ensure appropriate systemic and local therapies are selected (NCCN, 2026; NCI, 2024). Superior sulcus (Pancoast) tumors represent a distinct anatomic subset of NSCLC characterized by apical location and potential invasion of the chest wall, brachial plexus, and spine (NCCN, 2026).

Evidence Discussion

Contrast-enhanced CT of the chest with evaluation of the upper abdomen to the level of the adrenal glands is supported for initial staging of all individuals with NSCLC. This approach reliably identifies intrathoracic disease, liver metastases, and adrenal involvement, which are among the most common sites of distant spread. Routine pelvic imaging is not supported in asymptomatic individuals, as pelvic metastases are rare and inclusion increases radiation exposure without meaningful improvement in staging accuracy (NCCN, 2026; NCI, 2024).

FDG PET/CT is supported for comprehensive staging in NSCLC when not previously performed. PET/CT improves detection of occult nodal and distant metastatic disease compared with conventional imaging alone and frequently alters stage assignment and management decisions. Bone scan is reserved for situations in which PET/CT is unavailable, as PET/CT provides equivalent or superior assessment of osseous metastatic disease while reducing the need for multiple separate studies (NCCN, 2026).

Brain imaging is supported for individuals with stage IB–IV disease due to the documented prevalence of occult brain metastases. MRI of the brain without and with contrast demonstrates higher sensitivity than CT for detection of metastatic disease and is preferred whenever feasible. Although the prevalence of brain metastases is lower in stage IB disease, MRI may still be considered to avoid under-staging and inappropriate selection of curative-intent therapy in a small but clinically significant subset of individuals (NCCN, 2026; NCI, 2024).

For suspected superior sulcus tumors, MRI of the chest and cervical and thoracic spine is considered medically necessary in addition to standard staging studies. MRI

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provides superior specificity compared with CT for assessing chest wall invasion, neural involvement, and vertebral extension, which are critical determinants of resectability and treatment approach. Use of MRI in this setting reduces the risk of understaging locally advanced disease and supports appropriate multimodality treatment planning (NCCN, 2026).

Oncology Imaging Guidelines

Non-Small Cell Lung Cancer – Restaging/Recurrence (ONC-8.4)

ON.NL.0008.4.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Stage I or II individuals with non-small cell lung cancer who undergo definitive local treatment with surgery, radiation, or radiosurgery	• Restaging imaging is not considered medically necessary. See: **Surveillance/ Follow-Up (ONC-8.5)**
ANY of the following in individuals with non-small cell lung cancer: • After neoadjuvant treatment for evaluation of surgical resectability • Prior to starting adjuvant therapy • Inadequately resected disease	• CT Chest with contrast (CPT® 71260) **or** CT Chest without contrast (CPT® 71250)

Oncology Imaging Guidelines

Indication	Medically Necessary Imaging Study
Measurable metastatic disease in individuals with non-small cell lung cancer, undergoing active treatment, after every 2 cycles of chemotherapy	ANY or ALL of the following studies: • CT Chest with contrast (CPT® 71260) • CT Abdomen with contrast (CPT® 74160) ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) for known pelvic disease or pelvic symptoms • CT with contrast of other involved body areas In addition to the above studies, for individuals receiving systemic treatment for brain metastases: • MRI Brain without and with contrast (CPT® 70553) In addition to the above studies, for individuals receiving systemic treatment for bone metastases: • Bone scan • PET/CT is not indicated for routine evaluation of NSCLC that is metastatic outside the chest cavity
Suspected recurrence in individuals with non-small cell lung cancer	• CT Chest with contrast (CPT® 71260) **or** CT Chest without contrast (CPT® 71250); **and** CT Abdomen with contrast (CPT® 74160) ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) for known pelvic disease or pelvic symptoms For individuals with prior history of brain metastases or current signs or symptoms of brain metastasis: • MRI Brain without and with contrast (CPT® 70553)

Indication	Medically Necessary Imaging Study
ANY of the following in individuals with non-small cell lung cancer: • Biopsy proven recurrence localized to the chest cavity • Inconclusive findings on conventional imaging • To differentiate tumor from radiation scar/fibrosis • Stage IV with oligometastatic disease on conventional imaging and individual is a candidate for aggressive surgical resection or other localized treatment of metastases with a curative intent	• PET/CT (CPT® 78815)
ANY of the following in individuals with non-small cell lung cancer: • Following a demonstrated adequate response to neoadjuvant therapy if intracranial disease will preclude surgery • Documented recurrence/progression • New or worsening neurological signs or symptoms	• MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Non-small cell lung cancer (NSCLC) demonstrates variable patterns of response and recurrence depending on stage, histology, and treatment modality. Individuals treated with definitive local therapy for early stage disease have a lower risk of recurrence compared with those with locally advanced or metastatic disease, and this difference informs imaging strategies during and after treatment (NCCN, 2026).

Recurrence of NSCLC may be locoregional within the chest or present as distant metastatic disease. Common sites of recurrence include the lung parenchyma, mediastinal lymph nodes, liver, adrenal glands, brain, and bone. Imaging strategies therefore prioritize modalities capable of assessing these regions with high sensitivity while minimizing unnecessary radiation exposure (NCCN, 2026).

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Evidence Discussion

In individuals with measurable NSCLC undergoing active systemic therapy, periodic imaging with CT of the chest and abdomen is supported to assess treatment response and detect progression. Imaging every two cycles balances the need for timely identification of non-responding disease with avoidance of excessive radiation exposure and false-positive findings. Pelvic imaging is reserved for individuals with known pelvic involvement or new pelvic symptoms, as routine pelvic imaging does not provide additional staging value in asymptomatic patients (NCCN, 2026).

MRI of the brain with and without contrast is supported for individuals with known brain metastases receiving systemic therapy, as well as for those with new or worsening neurologic symptoms or documented systemic progression. MRI offers superior sensitivity for detecting intracranial disease compared with CT and allows accurate assessment of treatment response or progression, which directly influences surgical candidacy and systemic therapy decisions (NCCN, 2026).

CT imaging of the chest is also supported following neoadjuvant therapy to evaluate surgical resectability and post-operatively to establish a new baseline prior to initiation of adjuvant therapy. This approach improves surgical planning and ensures that residual or progressive disease is identified before additional treatment is undertaken, reducing the risk of futile or unsafe interventions (NCCN, 2026).

PET/CT is not routinely required for all individuals with suspected recurrence but is considered medically necessary in specific scenarios where conventional imaging is inconclusive, recurrence appears confined to the chest, or differentiation between viable tumor and post-treatment fibrosis is required. PET/CT is also supported in selected individuals with stage IV oligometastatic disease who are candidates for aggressive local therapy, as it improves detection of occult disease that would alter management and prevents inappropriate curative-intent interventions (NCCN, 2026).

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Non-Small Cell Lung Cancer – Surveillance/Follow-up (ONC-8.5)

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v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Stage I-II non-small cell lung cancer (treatment including surgery and/ or chemotherapy, but no radiation)	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) every 6 months for 3 years and then annually
Stage I-II non-small cell lung cancer treated with radiation therapy Stage III-IV (metastatic sites treated with definitive intent)	• CT Chest with contrast (CPT® 71260) **or** CT Chest without contrast (CPT® 71250) every 3-6 months for 3 years, every 6 months for 2 years and then annually
New lung nodule in individuals with non-small cell lung cancer	• See: **Lung Metastases (ONC-31.1)**

Background and Supporting Information

Following definitive treatment of non-small cell lung cancer (NSCLC), surveillance imaging is intended to detect disease recurrence and identify new primary lung cancers at a potentially curable stage. The risk of recurrence is highest during the first two to three years after treatment and varies by stage, treatment modality, and disease extent, which informs the recommended frequency and duration of follow up imaging (NCCN, 2026; Schneider et al., 2019).

Patterns of failure in NSCLC differ by stage. Individuals with early stage disease treated surgically or with chemotherapy alone have lower recurrence rates than those treated with radiation or those with locally advanced or metastatic disease treated with definitive intent. As a result, surveillance strategies are risk adapted, with more frequent imaging

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recommended for higher risk populations during the early post treatment period (NCCN, 2026).

Evidence Discussion

CT of the chest with or without contrast is supported for surveillance following definitive treatment of NSCLC due to its superior sensitivity compared with chest radiography for detecting recurrence and new primary lung cancers. For individuals with stage I–II disease treated without radiation, national guidelines support imaging every 6 months during the initial high-risk period and then annually thereafter. This approach detects the majority of clinically meaningful recurrences and second primaries while limiting cumulative radiation exposure (NCCN, 2026; Schneider et al., 2019).

Individuals treated with radiation therapy and those with stage III–IV disease who have undergone definitive treatment of metastatic sites have a higher risk of early relapse. More frequent chest CT surveillance during the first several years after treatment improves detection of recurrence in these higher-risk populations. Evidence demonstrates that increasing surveillance intensity beyond recommended intervals does not improve survival, supporting structured imaging schedules that balance benefit with potential harms (NCCN, 2026; Schneider et al., 2019).

Routine abdominal and pelvic imaging in asymptomatic individuals is not supported, as surveillance chest CT adequately evaluates the most common sites of recurrence and new primary disease. Additional imaging of the abdomen or pelvis increases radiation exposure and cost without demonstrated improvement in outcomes in the absence of symptoms or prior disease involvement (Schneider et al., 2019).

FDG-PET/CT is not recommended for routine surveillance due to high false-positive rates, increased radiation exposure, and the risk of unnecessary downstream procedures. Similarly, MRI of the brain is not routinely recommended for asymptomatic surveillance in NSCLC, as evidence does not demonstrate a survival or quality-of-life benefit from routine intracranial imaging in the absence of neurologic symptoms. Limiting surveillance to chest CT optimizes diagnostic yield while minimizing harm (NCCN, 2026; Schneider et al., 2019).

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Esophageal and GE Junction Cancer (ONC-9)

Guideline Page

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Esophageal and GE Junction Cancer – General Considerations (ONC-9.0)

ON.EJ.0009.0.C
v1.0.2027

Criteria

- Imaging for esophageal cancer is determined by the cell type and in which third of the esophagus it occurs.
- These guidelines may be used for imaging of esophageal and gastroesophageal (GE) junction cancers.

Background and Supporting Information

Esophageal cancer is broadly classified into two primary histologic subtypes: squamous cell carcinoma and adenocarcinoma. These subtypes differ in epidemiology, pathogenesis, and anatomic distribution within the esophagus. Squamous cell carcinoma arises from the native squamous epithelium and most commonly involves the proximal and middle portions of the esophagus, whereas adenocarcinoma arises from glandular epithelium and typically occurs in the distal esophagus, often in association with the GE junction (NCCN, 2026).

Tumor location within the esophagus is closely associated with histologic type and is an important determinant of clinical evaluation and management. Cancers of the upper and middle thirds are most frequently squamous cell carcinomas, while cancers of the distal third and GE junction are predominantly adenocarcinomas. The Siewert classification is commonly used to characterize tumors involving the GE junction and helps guide staging and treatment, with distal esophageal and true junctional tumors managed similarly (NCCN, 2026).

Risk factors also differ by histology and align with anatomic distribution. Squamous cell carcinoma is strongly associated with environmental exposures such as tobacco and alcohol use, as well as other risk factors including prior caustic injury and certain genetic syndromes. In contrast, adenocarcinoma is closely linked to gastroesophageal reflux disease (GERD), obesity, and Barrett's esophagus, a premalignant condition characterized by specialized intestinal metaplasia of the distal esophagus (NCCN, 2026).

Barrett's esophagus represents a key precursor lesion for adenocarcinoma and is associated with increased risk of malignant progression, particularly in individuals with chronic GERD and elevated body mass index. The presence of Barrett's epithelium and its progression through dysplasia to adenocarcinoma underlies the predominance

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of adenocarcinoma in the distal esophagus and GE junction, especially in Western populations (NCCN, 2026).

Health Equity Considerations

Esophageal and GE junction cancers demonstrate marked inequities across incidence, stage at diagnosis, and outcomes that reflect the influence of social determinants of health. Population-level data show persistent disparities by sex, race and ethnicity, and geography, with men experiencing substantially higher incidence and mortality rates and rural populations demonstrating worsening mortality trends over time compared with urban populations (Elnaggar et al., 2025). Racial and ethnic minority populations are more likely to be diagnosed with advanced-stage disease, contributing to poor survival despite overall modest improvements in mortality at the national level (Elnaggar et al., 2025; Tustumi et al., 2024). Early detection remains challenging, as most individuals with esophageal adenocarcinoma and GE junction adenocarcinoma present with locally advanced or metastatic disease, underscoring structural barriers to timely diagnostic evaluation and surveillance, particularly for individuals with limited access to specialty care (Agarwal et al., 2024).

After diagnosis, disparities persist in access to timely imaging, multimodality staging, and definitive treatment. Lower educational attainment and lack of private insurance are strongly associated with treatment delays, lower likelihood of surgical intervention, and worse overall survival, independent of tumor characteristics (Tustumi et al., 2024). Patients residing in rural or lower-resource settings face additional barriers related to geographic distance from high-volume centers and limited availability of advanced imaging needed for accurate staging and treatment planning (Elnaggar et al., 2025). Evidence suggests that when individuals have equitable access to comprehensive imaging, staging, and guideline-concordant therapy, outcomes improve regardless of socioeconomic status, reinforcing the importance of standardized, evidence-based imaging pathways (Agarwal et al., 2024; Tustumi et al., 2024).

Oncology Imaging Guidelines

Esophageal and GE Junction Cancer – Suspected/Diagnosis (ONC-9.1)

ON.EJ.0009.1.A

v1.0.2027

- See: **Dysphagia and Upper Digestive Tract Disorders (NECK-3.1)** in the Neck Imaging Guidelines for evaluation of suspected esophageal malignancy.

Oncology Imaging Guidelines

Esophageal and GE Junction Cancer – Initial Work-up/Staging (ONC-9.2)

ON.EJ.0009.2.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Biopsy proven esophageal or GE junction cancer	• CT Chest (CPT® 71260) and CT Abdomen (CPT® 74160) with contrast ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) instead of CT Abdomen if there are pelvic signs or symptoms
In addition to the above, for any of the following in individuals with esophageal or GE junction cancer: • Upper 1/3 of esophagus • Neck mass	• CT Neck with contrast (CPT® 70491)
If no evidence of metastatic disease on conventional imaging in individuals with esophageal or GE junction cancer	• PET/CT (CPT® 78815)

Background and Supporting Information

Accurate initial staging of esophageal and gastroesophageal junction cancers is essential to determine resectability, identify metastatic disease, and guide treatment selection. The staging process incorporates cross sectional imaging, functional imaging, and endoscopic techniques to define tumor location, depth of invasion, nodal involvement, and distant spread using the TNM classification system (NCCN, 2026).

Tumor location within the esophagus influences patterns of lymphatic spread and guides additional imaging. Cancers involving the upper third of the esophagus have a higher likelihood of cervical nodal involvement, which may necessitate imaging of the neck for comprehensive staging. Accurate delineation of nodal disease across cervical, mediastinal, and abdominal regions is essential for selecting appropriate multimodality therapy (NCCN, 2026).

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Evidence Discussion

Cross-sectional imaging with contrast-enhanced CT of the chest and abdomen is a first-line modality for initial staging because it reliably defines the location of the primary tumor and its relationship to surrounding structures, which is critical for determining resectability and planning therapy. CT also identifies regional nodal disease and common sites of metastases, providing a comprehensive baseline assessment. Restricting pelvic imaging to individuals with pelvic signs or symptoms is supported by evidence demonstrating that routine pelvic evaluation has lower diagnostic yield and increases unnecessary radiation exposure without improving staging accuracy (NCCN, 2026).

Additional imaging of the neck is supported in individuals with tumors involving the upper third of the esophagus or with clinical concern for cervical disease, such as a neck mass. This recommendation reflects known patterns of lymphatic drainage, as proximal esophageal tumors frequently spread to cervical lymph nodes. Inclusion of neck imaging in these cases improves detection of clinically significant nodal disease and reduces the risk of understaging, which could otherwise lead to inappropriate treatment selection (NCCN, 2026).

FDG PET/CT is supported following conventional CT imaging when no evidence of metastatic disease is identified, as it provides superior sensitivity for detecting occult distant metastases. This has direct clinical benefit by preventing inappropriate curative-intent therapies in individuals with unrecognized metastatic disease and facilitating appropriate systemic or palliative treatment. However, PET/CT has limitations in local staging, including reduced accuracy for determining depth of tumor invasion and distinguishing between early T stages, as well as limited reliability in assessing locoregional nodal disease due to metabolic activity from the primary tumor (NCCN, 2026).

The sequential use of CT followed by PET/CT balances diagnostic yield with minimization of unnecessary imaging. CT provides essential anatomic detail for staging and treatment planning, while PET/CT refines detection of distant disease. This combined approach enhances staging accuracy, improves treatment selection, and reduces the risks associated with overtreatment or misclassification, while avoiding overuse of advanced imaging modalities when not clinically indicated (NCCN, 2026).

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Esophageal and GE Junction Cancer – Restaging/Recurrence (ONC-9.3)

ON.EJ.0009.3.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
• After completion of primary therapy (to include chemotherapy and/or chemoradiotherapy), prior to surgery in individuals with esophageal or GE junction cancer • After completion of chemoradiation therapy with definitive intent (i.e., no metastatic disease and no anticipated resection surgery) in individuals with esophageal or GE junction cancer	Any ONE of the following, not both: • PET/CT (CPT® 78815) no sooner than 5 weeks post completion of radiation therapy OR • CT Chest (CPT® 71260) and CT Abdomen (CPT® 74160) with contrast ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) instead of CT Abdomen if there are pelvic signs or symptoms or known pelvic disease
Post-surgical resection in individuals with esophageal or GE junction cancer	• See: **Surveillance/Follow-up (ONC-9.4)**
Monitoring response to chemotherapy for stage IV/ metastatic esophageal or GE junction cancer	Every 2 cycles of treatment (~every 6-8 weeks): • CT Abdomen with contrast (CPT® 74160) • CT Chest with contrast (CPT® 71260)
• If conventional imaging is inconclusive in individuals with esophageal or GE junction cancer **or** • Salvage surgical candidate with recurrence and no metastatic disease documented by conventional imaging in individuals with esophageal or GE junction cancer	• PET/CT (CPT® 78815)

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Indication	Medically Necessary Imaging Study
For ANY of the following in individuals with esophageal or GE junction cancer: • Signs or symptoms of recurrence • Biopsy proven on follow-up endoscopy • Recurrence suggested by other imaging (i.e., chest x-ray or barium swallow)	• CT Chest (CPT® 71260) and CT Abdomen (CPT® 74160) with contrast
If previously involved or new signs or symptoms in individuals with esophageal or GE junction cancer	• CT Pelvis with contrast (CPT® 72193) and/or CT Neck with contrast (CPT® 70491)

Background and Supporting Information

Restaging in esophageal and gastroesophageal junction cancers is performed after completion of initial therapy to evaluate response, determine resectability, and identify persistent or progressive disease. Management strategies vary depending on whether treatment intent is curative or palliative, with restaging imaging playing a central role in guiding subsequent surgical, systemic, or palliative approaches (NCCN, 2026).

Evaluation for recurrence may be triggered by clinical symptoms, endoscopic findings, or abnormalities identified on prior imaging. The distribution of recurrence can include locoregional disease or distant metastases, and imaging strategies are tailored accordingly, including targeted evaluation of previously involved regions or areas corresponding to new symptoms (NCCN, 2026).

Evidence Discussion

After completion of primary chemoradiation and prior to surgery, imaging with either contrast-enhanced CT or FDG PET/CT is supported to evaluate treatment response and detect persistent or metastatic disease. PET/CT provides functional assessment and may identify metabolically active residual disease or occult metastases not visualized on CT; however, it is susceptible to false-positive findings due to post-radiation inflammation. Delaying PET/CT imaging until several weeks after completion of radiation reduces this limitation and improves specificity, supporting its selective use in this setting (NCCN, 2026).

CT of the chest and abdomen with contrast remains an appropriate alternative for restaging because it provides reliable anatomic assessment of residual tumor and

metastatic spread. Limiting pelvic imaging to individuals with pelvic symptoms or known disease is supported by the low prevalence of isolated pelvic metastases and the goal of minimizing unnecessary radiation exposure and cost. This targeted approach maintains diagnostic accuracy while avoiding routine imaging of low-yield regions (NCCN, 2026).

For individuals with stage IV or metastatic disease undergoing systemic therapy, serial CT imaging at defined treatment intervals supports timely assessment of response and progression. This approach allows early identification of treatment failure and facilitates modification of systemic therapy, which is critical for optimizing outcomes. More frequent imaging has not demonstrated additional benefit and increases cumulative radiation exposure, supporting interval imaging aligned with treatment cycles (NCCN, 2026).

PET/CT is additionally supported when conventional imaging is inconclusive or when evaluating potential candidates for salvage surgery in the absence of documented metastatic disease. In this context, PET/CT improves detection of occult metastases and helps avoid non-beneficial surgical interventions. Conversely, CT imaging is supported for evaluation of suspected recurrence based on symptoms, endoscopy, or other imaging findings, with expansion to include additional regions such as the neck or pelvis only when clinically indicated. This risk-adapted strategy improves diagnostic accuracy while minimizing unnecessary imaging and downstream interventions (NCCN, 2026).

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Esophageal and GE Junction Cancer – Surveillance/Follow-up (ONC-9.4)

ON.EJ.0009.4.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Stage 0-IA (Tis, T1a) esophageal or GE junction cancer	• No routine advanced imaging
Stage IB (T1b)-III esophageal or GE junction cancer	• CT Chest (CPT® 71260) and CT Abdomen (CPT® 74160) with contrast every 6 months for 2 years and then annually for 3 more years
Stage IV esophageal or GE junction cancer	• See: **General Guidelines (ONC-1.0)**

Background and Supporting Information

Surveillance following definitive treatment of esophageal and GE junction cancers is intended to detect recurrence, monitor treatment-related complications, and identify new symptoms requiring evaluation. Surveillance strategies vary by initial stage of disease and treatment modality, as recurrence risk and patterns differ significantly across disease stages (NCCN, 2026).

Evidence Discussion

For individuals with stage 0–IA (Tis, T1a) disease, routine advanced imaging is not supported because the risk of distant metastases is low after adequate endoscopic or curative treatment, and surveillance is primarily focused on endoscopic evaluation of the mucosa and residual Barrett's epithelium. Avoiding routine CT imaging in this population minimizes unnecessary radiation exposure and reduces the likelihood of incidental findings without compromising clinical outcomes (NCCN, 2026).

In contrast, individuals with stage IB–III disease have a substantially higher risk of recurrence due to deeper tumor invasion and increased likelihood of nodal involvement. Cross-sectional imaging with contrast-enhanced CT of the chest and abdomen at structured intervals is supported to detect recurrence during the period when risk is highest. Most recurrences occur within the first few years following treatment, supporting

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more frequent imaging early after therapy with a transition to less frequent imaging over time. This approach balances the benefit of early detection of clinically actionable recurrence against the harms of excessive imaging, including cumulative radiation exposure, cost, and false-positive findings. Interval CT imaging allows identification of resectable or treatable recurrence and facilitates timely initiation of systemic or local therapy, while avoiding unnecessary imaging in lower-risk populations (NCCN, 2026).

For individuals with stage IV disease, imaging is guided by treatment status and clinical need, with interval CT imaging used to monitor response to therapy or detect progression. This strategy supports appropriate adjustment of systemic therapy and avoids both under-imaging, which could delay recognition of progression, and over-imaging, which may not provide additional clinical benefit in stable or asymptomatic individuals (NCCN, 2026).

Oncology Imaging Guidelines

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v1.0.2027

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Other Thoracic Tumors (ONC-10)

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Malignant Pleural Mesothelioma – Suspected/Diagnosis (ONC-10.1)

ON.OT.0010.1.A

v1.0.2027

- See: **Asbestos Exposure (CH-9.1)** in the Chest Imaging Guidelines for evaluation of suspected mesothelioma.

Oncology Imaging Guidelines

Malignant Pleural Mesothelioma – Initial Work-up/Staging (ONC-10.2)

ON.OT.0010.2.A
v1.0.2027

Criteria

- Signs and symptoms of metastatic disease in body areas not addressed in ONC-10 may be imaged according to their respective sections in ONC-31.

Indication	Medically Necessary Imaging Study
Cytologically or pathologically proven malignant pleural mesothelioma	• CT Chest (CPT® 71260) **and** CT Abdomen (CPT® 74160) with contrast ◦ CT Abdomen and Pelvis with contrast (CPT® 74177)instead of CT Abdomen if there are pelvic signs or symptoms or prior pelvic involvement
For EITHER of the following in individuals with malignant pleural mesothelioma: • No evidence of distant metastatic disease on CT imaging • Inconclusive conventional imaging	• PET/CT (CPT® 78815)
Suspicion of possible chest wall, spinal, diaphragmatic, or vascular involvement based on CT imaging in individuals with malignant pleural mesothelioma	• MRI Chest without and with contrast (CPT® 71552)

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Background and Supporting Information

Malignant pleural mesothelioma is an aggressive malignancy arising from mesothelial cells of the pleura and is associated with a poor prognosis, with most patients presenting with advanced disease at diagnosis. Accurate staging is critical for determining treatment options, including surgical resectability and the need for systemic therapy, and is typically performed using a combination of cross sectional and functional imaging modalities (Bou Samra et al., 2023; NCCN, 2026).

Evidence Discussion

Contrast-enhanced CT of the chest and abdomen is the foundation of initial staging because it provides reliable assessment of both intrathoracic disease and common extrathoracic metastatic sites, particularly the liver. CT offers superior evaluation of lung parenchyma and nodal disease compared with other modalities and is essential for determining disease extent and guiding treatment planning. The routine inclusion of abdominal imaging is supported by the frequency of hepatic metastases, whereas limiting pelvic imaging to patients with specific clinical indications reduces unnecessary radiation exposure without compromising diagnostic yield (NCCN, 2026).

MRI of the chest is supported when there is suspicion of invasion into adjacent structures, such as the chest wall, diaphragm, spine, or major vessels. Although MRI is less effective than CT for evaluating lung parenchyma, it provides improved soft tissue contrast and can better delineate local tumor extension in complex anatomic regions. This targeted use of MRI enhances staging accuracy in selected patients while avoiding routine use in all cases (NCCN, 2026).

FDG PET/CT is not recommended as a first-line imaging modality due to limitations in distinguishing malignant disease from benign inflammatory or asbestos-related changes, which may demonstrate variable FDG uptake. Additionally, PET/CT may underestimate local tumor extent and is therefore insufficient as a standalone staging tool. However, PET/CT provides important incremental value in detecting occult metastatic disease and is particularly useful when conventional imaging is negative or inconclusive (NCCN, 2026).

The use of PET/CT following conventional imaging is further supported by evidence demonstrating that a significant proportion of patients initially considered candidates for surgical resection may be reclassified as having unresectable disease after detection of previously unrecognized metastases. This approach improves patient selection for surgery, avoids non-beneficial invasive procedures, and ensures appropriate allocation to systemic or palliative therapies, thereby optimizing overall clinical management (NCCN, 2026).

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Health Equity Considerations

Malignant pleural mesothelioma (MPM) is a rare and aggressive malignancy with outcomes that are strongly influenced by nonclinical factors across the care continuum. Disease burden and survival vary by age, sex, race, and socioeconomic status, reflecting long-standing inequities related to historical asbestos exposure, access to specialty care, and delays in diagnosis. Older age and male sex are consistently associated with worse survival, while younger age and female sex are associated with more favorable outcomes, even after adjustment for stage and treatment (Freudenberger & Shah, 2021; Alnajar et al., 2023). Racial disparities are also evident: Black individuals experience significantly higher mortality and are more likely to be diagnosed at later stages, which may reflect differences in timely access to diagnostic imaging, specialty referral, and comprehensive staging evaluations (Freudenberger & Shah, 2021; Alnajar et al., 2023).

Inequities persist after diagnosis, particularly in access to advanced imaging, multimodality treatment, and high-volume academic centers. Individuals with lower income, lower educational attainment, Medicaid insurance, or no insurance are less likely to receive guideline-concordant care, including definitive surgical intervention and coordinated multimodality therapy, which are associated with improved survival in operable MPM (Freudenberger & Shah, 2021; Alnajar et al., 2023). Geographic barriers further compound these disparities; treatment at nonacademic or low-resource centers and limited ability to travel to specialized facilities are associated with worse outcomes, whereas receipt of care at high-volume academic centers even when requiring longer travel distances is linked to improved survival (Alnajar et al., 2023). Standardized, evidence-based imaging guidelines for MPM can help mitigate these inequities by supporting timely diagnosis, accurate staging, and consistent treatment assessment, thereby promoting more equitable access to high-quality care across diverse populations.

Oncology Imaging Guidelines

Malignant Pleural Mesothelioma – Restaging/Recurrence (ONC-10.3)

ON.OT.0010.3.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Signs or symptoms of recurrence in individuals with malignant pleural mesothelioma	• CT Chest (CPT® 71260) **and** CT Abdomen (CPT® 74160) with contrast ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) instead of CT Abdomen if there are pelvic signs or symptoms or prior pelvic involvement
Treatment with chemotherapy in individuals with malignant pleural mesothelioma	Every 2 cycles: • CT Chest (CPT® 71260) **and** CT Abdomen (CPT® 74160) with contrast ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) instead of CT Abdomen if there are pelvic signs or symptoms or prior pelvic involvement
Following induction chemotherapy prior to surgical resection in individuals with malignant pleural mesothelioma	• CT Chest (CPT® 71260) **and** CT Abdomen (CPT® 74160) with contrast ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) instead of CT Abdomen if there are pelvic signs or symptoms or prior pelvic involvement • PET/CT (CPT® 78815) if no evidence of distant metastatic disease
Inconclusive CT Chest in individuals with malignant pleural mesothelioma	• MRI Chest without and with contrast (CPT® 71552)

Evidence Discussion

Contrast-enhanced CT of the chest and abdomen is the primary imaging modality for monitoring malignant pleural mesothelioma (MPM), as it enables consistent evaluation of pleural tumor burden, locoregional extension, and intra-abdominal spread. CT is

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recommended for both staging and follow-up because it reliably demonstrates pleural thickening, effusion, and patterns of progression, which are essential for identifying recurrence or treatment failure (Popat et al., 2022; Tsao et al., 2022). The use of CT chest and abdomen in individuals with signs or symptoms of recurrence is therefore supported by its ability to detect both thoracic and upper abdominal disease, allowing accurate identification of relapse and guiding appropriate changes in management (Popat et al., 2022).

Serial CT imaging during chemotherapy is supported by the need for standardized and reproducible response assessment in MPM. Due to the diffuse, rind-like growth pattern of mesothelioma, conventional tumor response metrics are inadequate, and modified RECIST (mRECIST) criteria were developed specifically for CT-based measurements of pleural thickness. These criteria allow categorization of response and progression, providing objective evidence to guide ongoing therapy (Tsao et al., 2022). Imaging every 2 cycles enables timely detection of disease progression or response, minimizing exposure to ineffective therapies while optimizing treatment selection. Although repeated CT imaging results in cumulative radiation exposure, this risk is outweighed by the clinical benefit of accurate disease monitoring in a malignancy with limited therapeutic windows (Popat et al., 2022; Tsao et al., 2022).

For individuals undergoing induction chemotherapy prior to possible surgical resection, CT imaging at completion of therapy is essential for reassessment of disease extent and operability. CT provides critical anatomic detail regarding tumor distribution and invasion, which directly impacts surgical candidacy (Popat et al., 2022; Tsao et al., 2022). In addition, PET/CT has an established complementary role in identifying occult extrathoracic metastatic disease, which may not be apparent on CT alone. Evidence demonstrates that a subset of patients considered for surgery are upstaged based on PET/CT findings, helping to avoid non-beneficial invasive procedures and redirect treatment toward systemic or radiation-based approaches (Tsao et al., 2022). While PET/CT introduces additional radiation exposure and potential false positives from inflammatory uptake, its selective use in this context improves staging accuracy and clinical decision-making.

MRI of the chest is an important adjunct when CT findings are inconclusive. MRI provides superior soft tissue contrast and may better delineate chest wall, diaphragmatic, and mediastinal invasion compared with CT, which is particularly relevant when distinguishing persistent tumor from treatment-related changes. This distinction is critical because post-treatment fibrosis and tumor can demonstrate overlapping features on other modalities (Tsao et al., 2022). Although MRI is not routinely required, its use when CT is nondiagnostic enhances diagnostic certainty and helps avoid both under- and overtreatment. Overall, the imaging strategy outlined in the clinical criteria balances the benefits of accurate disease assessment and treatment planning against the potential harms of radiation exposure, contrast risks, and imaging-related uncertainty, supporting its clinical utility in restaging MPM.

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Malignant Pleural Mesothelioma – Surveillance/Follow-up (ONC-10.4)

ON.OT.0010.4.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with malignant pleural mesothelioma	• CT Chest with contrast (CPT® 71260) and previously involved regions every 3 months for 2 years, then annually thereafter

Evidence Discussion

Contrast-enhanced CT of the chest, including previously involved regions, is the standard imaging modality for surveillance in malignant pleural mesothelioma (MPM) due to its established role in detecting locoregional recurrence and monitoring disease progression. CT provides consistent visualization of pleural tumor burden, chest wall involvement, and spread to adjacent and intra-abdominal structures, which are common patterns of disease relapse (Popat et al., 2022). Although formal consensus intervals are not uniformly defined, The European Society of Medical Oncology supports CT-based surveillance following treatment, recognizing its utility in identifying recurrent disease and guiding further management (Popat et al., 2022).

The recommendation for surveillance imaging every 3 months for the first 2 years reflects the natural history and prognosis of MPM, which is characterized by high rates of early recurrence and limited long-term survival. Median survival remains less than 2 years for many patients, particularly those with unresectable disease, indicating that the highest risk period for recurrence occurs early in the disease course (Popat et al., 2022). Close interval CT imaging during this period enables earlier detection of recurrence, allowing timely initiation of additional therapy or transition to palliative care when appropriate. After 2 years, the transition to less frequent (annual) imaging reflects the declining probability of recurrence over time.

Surveillance CT also provides objective assessment of disease status using reproducible imaging findings that correlate with clinical progression. Because MPM often spreads along pleural surfaces and into adjacent compartments, CT evaluation of both the chest and previously involved regions is critical to ensure comprehensive surveillance. This approach is supported by the known patterns of disease extension and the limitations of clinical evaluation alone in detecting early recurrence (Popat et al.,

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2022). While imaging beyond the chest may be individualized based on prior disease distribution, CT remains the foundational modality for longitudinal disease monitoring.

Potential harms of surveillance imaging include cumulative radiation exposure, risks associated with intravenous contrast, and the possibility of detecting clinically insignificant findings that may lead to additional testing. However, these risks are outweighed by the clinical benefit of early identification of recurrence in a disease with aggressive behavior and limited therapeutic windows. Regular CT surveillance allows clinicians to identify disease relapse before the onset of significant symptoms, optimize the timing of systemic or local therapies, and support informed prognostic discussions, thereby aligning imaging practices with the overall goals of care in MPM (Popat et al., 2022).

Oncology Imaging Guidelines

Thymoma and Thymic Carcinoma – Suspected/Diagnosis (ONC-10.5)

ON.OT.0010.5.A
v1.0.2027

Criteria

- The proceeding guidelines are intended to be used for imaging of malignant mediastinal masses.
- See: **Mediastinal Mass (CH-20.1)** in the Chest Imaging Guidelines for evaluation of mediastinal mass without confirmation of malignancy.
- See: **Bronchopulmonary or Thymic Carcinoid – Initial Staging (ONC-15.6)** for imaging guidelines for thymic carcinoid.

Health Equity Considerations

Thymoma and thymic carcinoma are rare thoracic malignancies for which outcomes are influenced by geographic and sociodemographic factors that affect access to timely diagnosis and specialized care. Population-based analyses demonstrate clinically meaningful rural–urban disparities, with individuals residing in rural areas experiencing worse disease-specific survival compared with urban counterparts, even after adjustment for age, sex, race/ethnicity, histology, and stage at diagnosis (Cascone et al., 2024). Rural individuals are also more likely to have lower household income and reduced access to routine preventive and primary care services, which may delay incidental detection of these often asymptomatic tumors and limit timely referral for advanced imaging and multidisciplinary evaluation (Cascone et al., 2024). Given the insidious presentation of many thymic tumors, inequities in access to imaging and specialty consultation can disproportionately affect individuals in resource-limited or geographically isolated settings.

Emerging genomic data further highlight the importance of equitable representation and access to advanced diagnostics in thymic carcinoma. Large-scale molecular analyses reveal sex-associated and race-associated mutational patterns, including preliminary signals of distinct genomic alterations in underrepresented populations, such as Pacific Islander individuals, though conclusions are limited by small sample sizes (Chudziak et al., 2026). Incomplete demographic annotation and underrepresentation of minority groups in genomic databases underscore structural barriers to participation in precision oncology research and molecular profiling (Chudziak et al., 2026). Because comprehensive imaging and genomic characterization increasingly inform staging, recurrence assessment, and therapeutic decision-making in thymic malignancies, standardized imaging guidelines play a critical role in promoting equitable care. Consistent application of evidence-based imaging pathways can help reduce disparities

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related to geography, referral patterns, and access to specialized centers, supporting accurate diagnosis and management for diverse populations with thymoma and thymic carcinoma.

Oncology Imaging Guidelines

Thymoma and Thymic Carcinoma – Initial Work-up/Staging (ONC-10.6)

ON.OT.0010.6.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Encapsulated or invasive limited thymoma or thymic carcinoma	• CT Chest with contrast (CPT® 71260)
Extensive mediastinal involvement on CT Chest in individuals with thymoma or thymic carcinoma	• CT Abdomen with contrast (CPT® 74160) • CT Neck with contrast (CPT® 70491)
Inconclusive finding on CT in individuals with thymoma or thymic carcinoma	ONE of the following: • PET/CT (CPT® 78815) • MRI Chest without and with contrast (CPT® 71552)
Preoperative planning in individuals with thymoma or thymic carcinoma	• MRI Chest without and with contrast (CPT® 71552)
Thymic Carcinomas	• Image according to **Non-Small Cell Lung Cancer - Initial Work-up/Staging (ONC-8.3)**

Evidence Discussion

Contrast-enhanced CT of the chest is the primary imaging modality for the initial work-up of thymoma and thymic carcinoma because it provides detailed anatomic characterization of anterior mediastinal masses and is essential for diagnosing, staging, and assessing resectability. CT typically demonstrates a well-defined round or oval mass in the thymic bed without associated lymphadenopathy in thymoma, allowing differentiation from other mediastinal pathologies and guiding further management (NCCN, 2025). The high spatial resolution of CT enables evaluation of tumor size, invasion into adjacent mediastinal structures, and features suggestive of malignancy, supporting its use for both encapsulated and invasive limited disease.

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When extensive mediastinal involvement is identified on CT chest, additional cross-sectional imaging of the neck and abdomen improves staging accuracy by evaluating for regional lymph node involvement and extrathoracic disease. Thymic carcinomas, in particular, demonstrate a higher propensity for lymphatic and distant metastases compared to thymomas, which more commonly remain localized (NCCN, 2025). PET/CT complements CT by identifying metabolically active nodal disease or distant metastases and has shown utility in assessing lymph node involvement and extrathoracic spread, although its role is adjunctive rather than primary in initial staging (Lococo et al., 2021). The combination of anatomic and metabolic imaging improves staging completeness and reduces the risk of understaging.

For indeterminate CT findings, PET/CT or MRI provides additional diagnostic clarification. PET/CT offers functional characterization, with higher FDG uptake correlating with more aggressive histology, higher tumor grade, and more advanced stage, thereby supporting risk stratification (Ito et al., 2021; Lococo et al., 2021). MRI offers superior soft tissue contrast and is particularly useful for distinguishing thymic tumors from cystic lesions or thymic hyperplasia, as well as evaluating invasion into adjacent structures such as the pericardium, vessels, and chest wall (NCCN, 2025). However, PET/CT may produce false-positive results due to physiologic or inflammatory uptake, and MRI can be limited by artifact or overlap in imaging characteristics, necessitating integration with CT findings.

MRI is also critical for preoperative planning because accurate assessment of local invasion directly impacts surgical approach and resectability. Complete surgical resection is the primary determinant of prognosis in thymic epithelial tumors, and imaging must accurately delineate tumor extension into adjacent structures to guide operative strategy (NCCN, 2025). While advanced imaging increases diagnostic accuracy, potential harms include increased cost, limited availability, contrast-related risks, and false-positive findings. Despite these limitations, the combined use of CT, PET/CT, and MRI provides complementary anatomic and functional information that supports accurate staging, optimal treatment planning, and avoidance of unnecessary or non-beneficial interventions.

Oncology Imaging Guidelines

Thymoma and Thymic Carcinoma – Restaging/Recurrence (ONC-10.7)

ON.OT.0010.7.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Adjuvant therapy following surgical resection in individuals with thymoma or thymic carcinoma	• Follow surveillance imaging
Following induction chemotherapy prior to surgical resection, if no evidence of metastatic disease in individuals with thymoma or thymic carcinoma	ONE of the following: • PET/CT (CPT® 78815) • CT Chest with contrast (CPT® 71260) • MRI Chest without and with contrast (CPT® 71552)
For suspected recurrence in individuals with thymoma or thymic carcinoma	• CT Chest with contrast (CPT® 71260)
Recurrence with extensive mediastinal involvement on CT Chest in individuals with thymoma or thymic carcinoma	• CT Abdomen with contrast (CPT® 74160) • CT Neck with contrast (CPT® 70491)
Inconclusive finding on CT in individuals with thymoma or thymic carcinoma	ONE of the following: • PET/CT (CPT® 78815) • MRI Chest without and with contrast (CPT® 71552)

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Indication	Medically Necessary Imaging Study
Metastatic disease on chemotherapy in individuals with thymoma or thymic carcinoma	• CT Neck (CPT® 70491), CT Chest (CPT® 71260), and CT Abdomen (CPT® 74160) with contrast, every 2 cycles of therapy
Thymic carcinomas	• See: **Non-Small Cell Lung Cancer Restaging/ Recurrence (ONC-8.4)**

Evidence Discussion

In the setting of restaging following induction chemotherapy prior to surgical resection, imaging plays a critical role in determining treatment response and resectability. Functional imaging with PET/CT has demonstrated correlation between metabolic response and pathologic response in thymic epithelial tumors, supporting its use to confirm absence of metastatic disease and to guide surgical decision-making (NCCN, 2025). Cross-sectional imaging with contrast-enhanced CT or MRI of the chest also provides detailed anatomic evaluation of tumor burden and invasion into adjacent mediastinal structures, both of which are essential for assessing operability and planning resection. The availability of multiple imaging options allows tailoring based on clinical context, balancing diagnostic accuracy with patient-specific considerations such as contraindications to contrast or radiation exposure.

For suspected recurrence, contrast-enhanced CT of the chest is the primary imaging modality because recurrence of thymoma and thymic carcinoma most commonly occurs within the thorax, including pleural or mediastinal sites. Recurrent disease is often locoregional rather than distant, making CT particularly effective for detecting changes in tumor size, new pleural implants, or mediastinal progression (NCCN, 2025). When extensive mediastinal involvement is identified, additional CT imaging of the neck and abdomen is appropriate to evaluate for lymphatic and extrathoracic spread, which is more common in thymic carcinoma and has implications for staging and treatment selection. This approach ensures comprehensive evaluation of disease extent while avoiding unnecessary imaging in cases limited to the chest.

When CT findings are inconclusive, PET/CT or MRI provides complementary information that improves diagnostic confidence. PET/CT can identify metabolically active disease and may detect sites of recurrence not apparent on CT, whereas MRI provides superior soft tissue contrast and is particularly useful in distinguishing recurrent tumor from postoperative or treatment-related changes in the mediastinum (NCCN, 2025). However, PET/CT may be limited by false-positive uptake due to inflammation, and MRI may be affected by overlapping imaging characteristics, highlighting the importance of selective use in cases where CT is non-diagnostic. These adjunct

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modalities improve diagnostic accuracy while minimizing unnecessary additional imaging.

For individuals with metastatic disease undergoing chemotherapy, serial CT imaging of the neck, chest, and abdomen every 2 cycles provides objective assessment of treatment response and detects progression in both thoracic and extrathoracic sites. This approach is supported by the known patterns of spread and the need for timely reassessment in aggressive disease, particularly thymic carcinoma, which frequently presents with advanced or metastatic involvement (NCCN, 2025). Although repeated imaging introduces cumulative radiation exposure and contrast-related risks, these are outweighed by the clinical benefit of accurately monitoring response, guiding continuation or modification of therapy, and avoiding ineffective treatment in a population with variable disease behavior and prognosis.

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Thymoma and Thymic Carcinoma – Surveillance/Follow-up (ONC-10.8)

ON.OT.0010.8.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Thymoma, R0 resection	• CT Chest with contrast (CPT® 71260) and previously involved regions every 6 months for 2 years, then annually until year 10
Thymoma, R1 or R2 resection	• CT Chest with contrast (CPT® 71260) and previously involved regions every 6 months for 2 years, then annually until year 10
Thymic carcinoma, R0 resection	• CT Chest with contrast (CPT® 71260) every 6 months for 2 years and then annually until year 5
Thymic carcinoma, R1 or R2 resection	• CT Chest with contrast (CPT® 71260) and previously involved regions every 3 months for 2 years, then annually until year 5

Evidence Discussion

Surveillance imaging for thymoma following surgical resection is based on the known natural history of the disease, including the potential for late recurrence even after complete (R0) resection. Thymomas are generally indolent tumors, but recurrence can occur many years after initial treatment, with documented cases of recurrence more than 10 years post-resection (NCCN, 2025). As a result, long-term imaging surveillance with contrast-enhanced CT of the chest is supported, and inclusion of previously involved regions ensures comprehensive evaluation of common recurrence sites such as the pleura and mediastinum. The interval of every 6 months for the first 2 years reflects the higher risk of recurrence during this period, with transition to annual imaging thereafter aligning with the slower growth kinetics of relapsed thymoma.

For individuals with incomplete resection (R1 or R2) thymoma, continued surveillance with the same frequency and duration is appropriate given the increased risk of recurrence compared to completely resected disease. Residual microscopic or macroscopic disease increases the likelihood of both early and late recurrence, supporting consistent imaging intervals to facilitate timely detection and intervention

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(NCCN, 2025). Despite these risks, CT remains the preferred modality due to its ability to reliably detect subtle changes in pleural or mediastinal disease over time, which are often not clinically apparent.

Surveillance strategies for thymic carcinoma differ due to its more aggressive biology and higher likelihood of early recurrence and distant metastases. Thymic carcinoma demonstrates higher recurrence rates and more rapid progression compared to thymoma, with shorter median time to recurrence reported in clinical series (NCCN, 2025). For patients with R0 resection, CT chest every 6 months for 2 years followed by annual imaging through year 5 reflects the period of highest recurrence risk. In patients with residual disease (R1 or R2 resection), more frequent imaging every 3 months during the first 2 years is supported by the increased likelihood of early disease progression, allowing for prompt identification of recurrence and adjustment of therapy.

The primary benefit of this surveillance approach is early detection of recurrence, which may allow for potentially curative or disease-controlling interventions such as repeat resection, radiation therapy, or systemic therapy. However, potential harms include cumulative radiation exposure, contrast-related risks, and the possibility of incidental findings leading to additional testing. Despite these limitations, the balance of evidence supports regular CT surveillance given the clinical importance of early recurrence detection in both thymoma and thymic carcinoma, particularly in the context of variable disease behavior and the potential for long-term survival following appropriate intervention (NCCN, 2025).

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Oncology Imaging Guidelines

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Breast Cancer (ONC-11)

Guideline Page

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Breast Cancer – General Considerations (ONC-11.0)

ON.BC.0011.0.A
v1.0.2027

Criteria

- This guideline applies to invasive carcinoma and ductal carcinoma in situ histologies of breast cancer.
- Advanced imaging to evaluate for distant metastases is not medically necessary for asymptomatic individuals with invasive carcinoma or ductal carcinoma in situ (DCIS).
- High-risk lesions, such as LCIS, ADH, and ALH are discussed in **Breast MRI Indications (BR-5.1)**.
- Bone scan has a high concordance rate with PET for detecting bone metastases.
- Scintimammography and Breast Specific Gamma Imaging (BSGI) are considered experimental, investigational, or unproven.
- For malignant phyllodes tumors of the breast, see **Sarcomas - Bone, Soft Tissue, and GIST (ONC-12)**

Evidence Discussion

Advanced imaging to evaluate for distant metastases is not supported in asymptomatic individuals with invasive breast cancer or ductal carcinoma in situ (DCIS), as evidence demonstrates low diagnostic yield in early-stage disease and no improvement in clinical outcomes. NCCN guidelines consistently emphasize that advanced staging studies, including PET/CT, CT, and bone scan, should not be routinely performed in asymptomatic individuals without clinical or laboratory findings suggestive of metastatic disease, as this approach reduces false-positive results, unnecessary biopsies, and downstream testing without impacting survival (NCCN, 2025; NCCN, 2026).

A symptom-driven imaging strategy provides clinical benefit by reserving advanced imaging for patients with higher pretest probability of metastatic disease, such as those with concerning symptoms, abnormal physical examination findings, or laboratory abnormalities. This targeted approach improves diagnostic accuracy and ensures appropriate use of imaging resources while minimizing harms associated with overuse, including radiation exposure, patient anxiety, and the potential for incidental findings that may lead to unnecessary interventions (NCCN, 2025).

Bone scintigraphy demonstrates a high concordance with PET imaging for detection of osseous metastases, supporting its use as an appropriate modality when there is clinical suspicion for bone involvement. However, similar to PET/CT, routine use of bone scans in asymptomatic individuals is not recommended due to low yield and risk of false-

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positive findings. Limiting imaging to clinically indicated scenarios preserves diagnostic value while avoiding overdiagnosis and overtreatment (NCCN, 2025).

Imaging modalities such as scintimammography and breast-specific gamma imaging are not supported due to insufficient evidence of clinical utility and lack of demonstrated improvement in outcomes compared to established imaging techniques. Avoiding these modalities reduces unnecessary cost and exposure to ionizing radiation without compromising diagnostic performance. Overall, the evidence supports a risk-adapted, symptom-based imaging strategy that prioritizes clinically meaningful detection of metastatic disease while minimizing unnecessary imaging and associated harms (NCCN, 2025; NCCN, 2026).

Health Equity Considerations

Breast cancer outcomes in the United States remain marked by persistent inequities across race, ethnicity, socioeconomic status, and geography, despite advances in screening, imaging, and treatment. Black women experience substantially higher mortality than non-Hispanic White women, including in early-stage, hormone receptor–positive disease treated with guideline-concordant therapy. Evidence from randomized trials and population-level modeling demonstrates worse recurrence and survival outcomes among Black women despite similar tumor genomics, recurrence scores, and use of systemic therapy, indicating that disparities are not fully explained by biology or treatment delivery alone (Albain et al., 2020; Wojcik et al., 2024). Structural and social determinants, including insurance coverage, neighborhood disadvantage, comorbidity burden, and reduced access to preventive care, exert a strong influence on stage at diagnosis and long-term outcomes, often outweighing the contribution of genetic ancestry itself (Iyer et al., 2023).

Disparities arise early in the care continuum and are closely linked to inequitable access to screening and diagnostic imaging. Racial and ethnic minoritized populations, individuals with lower income or education, uninsured or underinsured patients, and those living in rural or medically underserved areas consistently demonstrate lower screening utilization, delays in diagnostic follow-up, and reduced access to advanced imaging modalities such as digital breast tomosynthesis and supplemental ultrasound or MRI (Nayyar et al., 2023; Ozcan et al., 2023; Wilkerson et al., 2024). Geographic variation and health-system factors, including availability of multidisciplinary teams, specialty care resources, and navigation infrastructure, explain a substantial proportion of disparities in receipt of recommended therapies and survivorship outcomes (Hassett et al., 2025; Schneider et al., 2026). Standardized, evidence-based imaging guidelines are therefore essential to reducing inequities by supporting consistent screening, diagnostic evaluation, staging, and surveillance across care settings, while enabling equitable access to high-quality breast cancer care when integrated with patient navigation, community outreach, and attention to social risk factors (Bayard et al., 2022).

Breast Cancer – Suspected/Diagnosis (ONC-11.1)

ON.BC.0011.1.A
v1.0.2027

- See: **Breast MRI Indications (BR-5.1)** in the Breast Imaging Guidelines for evaluation of suspected breast cancer.

Oncology Imaging Guidelines

Breast Cancer – Initial Work-Up/Staging (ONC-11.2)

ON.BC.0011.2.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All newly diagnosed breast cancer or ductal carcinoma in situ	• Diagnostic bilateral mammogram and/or Ultrasound Breast (CPT® 76641 or CPT® 76642) and/or Ultrasound Axilla (CPT® 76882) are imaging modalities of choice • MRI Breast bilateral without and with contrast (CPT® 77049)
ANY of the following: • Atypical ductal hyperplasia (ADH) • Atypical lobular hyperplasia (ALH) • Lobular carcinoma in situ (LCIS)	See: **Breast MRI Indications (BR-5.1)**
ANY of the following: • Ductal carcinoma in situ • Stage I-III breast cancer	• For sentinel lymph node evaluation: Lymph system imaging (lymphoscintigraphy, CPT® 78195 ◦ SPECT/CT (CPT® 78830) if requested
Stages I, II, and operable stage III (N1 disease) breast cancer	• Routine systemic imaging is not medically necessary for initial staging of non-metastatic breast cancer in the absence of signs or symptoms

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Indication	Medically Necessary Imaging Study
ANY of the following in individuals with breast cancer: • Diagnosis of breast cancer with suspected or proven metastatic disease or biopsy-proven distant metastases/Stage IV disease (not locally advanced disease with three or less positive axillary nodes) • Signs or symptoms of systemic disease • Elevated liver function tests or tumor markers • Inflammatory breast cancer (stage T4d) • 4 or more axillary lymph nodes positive for cancer involvement (i.e., N2 disease, including Stage III N2)	ANY or ALL of the following: • CT Chest (CPT® 71260) **and** CT Abdomen and Pelvis (CPT® 74177) with contrast • Bone scan (CPT® 78306) (if PET/CT is not being performed)
ANY of the following in individuals with breast cancer: • Stage III N2 disease or higher • T4 disease • Inflammatory breast cancer (stage T4d)	In addition to the above: • FDG PET/CT (CPT® 78815 or 78816)
Inconclusive CT and/or bone scan in individuals with breast cancer	FDG PET/CT (CPT® 78815 or 78816)
Bone pain in individuals with breast cancer	• Bone scan (CPT® 78306) • PET/CT (CPT® 78815 or 78816) with Sodium Fluoride radiotracer if CT, MRI, Bone scan and FDG PET/CT scan are inconclusive for bone metastases • See: **Bone (Non-Vertebral) Metastases (ONC-31.5)** • See: **Spinal/Vertebral Metastases (ONC-31.6)**

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- ^{18}F-FES (fluoroestradiol) PET/CT scan is not considered medically necessary for initial staging.

Background and Supporting Information

Breast cancer staging encompasses evaluation of locoregional disease within the breast and regional lymph nodes, as well as assessment for distant metastatic disease. Tumor stage is determined by tumor size, nodal involvement, and presence of metastases, with early-stage disease (Stages I–II) generally confined to the breast and limited nodal regions, and advanced disease (Stage III–IV) reflecting more extensive nodal or distant spread (Expert Panel on Breast Imaging, 2024). Accurate initial staging is critical because management strategies and prognosis differ significantly across stages, and imaging plays a central role in defining the extent of disease prior to treatment planning.

Evidence Discussion

Diagnostic mammography and ultrasound are supported as primary imaging modalities for initial work-up because they provide reliable assessment of tumor presence, size, and locoregional extent with a favorable risk–benefit profile. These techniques are widely available, cost-effective, and avoid unnecessary downstream testing. Evidence-based guidelines emphasize their role as first-line imaging for staging, as they adequately define disease extent in most patients while minimizing harms associated with more advanced imaging (Expert Panel on Breast Imaging, 2024; NCCN, 2026).

Breast MRI provides higher sensitivity for detecting additional ipsilateral and contralateral malignancies and may improve delineation of tumor extent, particularly in dense breast tissue or invasive lobular carcinoma. MRI has demonstrated the ability to detect otherwise occult disease, including in cases with negative mammography, thereby potentially influencing surgical planning (Morrogh et al., 2007). However, multiple studies highlight that MRI is associated with increased false-positive findings, which can lead to additional imaging, biopsies, and more extensive surgery without consistent improvement in outcomes (Cozzi & Schiafno, 2023; Cheng et al., 2012). Furthermore, variability in diagnostic performance and limited evidence for survival benefit reinforce that MRI should be used selectively rather than routinely (Expert Panel on Breast Imaging, 2024; Peters et al., 2011; Kleer, 2000).

Sentinel lymph node evaluation is essential for staging; however, the incremental value of lymphoscintigraphy is limited. Although lymphoscintigraphy can identify alternative lymphatic drainage patterns, studies demonstrate that axillary sentinel lymph nodes are still identified in most patients regardless of mapping results, and axillary nodal positivity rates are not significantly influenced by drainage patterns (Chagpar et al., 2005). Given the limited impact on management and outcomes, routine use of lymphoscintigraphy adds cost and complexity without clear clinical benefit.

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Systemic imaging with CT, bone scan, or PET/CT is most beneficial in patients with suspected metastatic disease or high-risk clinical features. In early-stage, asymptomatic patients, evidence demonstrates a low prevalence of distant metastases, and routine imaging leads to a high rate of false-positive findings, increased costs, additional procedures, and delays in care without improving survival (Jochelson et al., 2013; NCCN, 2026; Expert Panel on Breast Imaging, 2024). Functional imaging such as FDG-PET/CT offers whole-body assessment and relatively high sensitivity but has lower specificity, increasing the likelihood of false-positive results and unnecessary diagnostic workup (Cheng et al., 2012). Collectively, these data support a risk-adapted strategy in which systemic imaging is reserved for patients with clinical suspicion or advanced disease, consistent with guideline recommendations.

Oncology Imaging Guidelines

Breast Cancer – Restaging/Recurrence (ONC-11.3)

ON.BC.0011.3.C
v1.0.2027

Criteria

- For imaging related to breast reconstruction, see: **Breast Reconstruction (BR-3.1)** in the Breast Imaging Guidelines

Indication	Medically Necessary Imaging Study
ANY of the following in individuals with breast cancer: • End of planned neoadjuvant chemotherapy to determine resectability • Biopsy proven local recurrence • Suspicion of recurrence with inconclusive mammogram and/or ultrasound (BIRADS 0) • Mammogram and/or ultrasound conflicts with physical exam	• MRI Breast Bilateral without and with contrast (CPT® 77049)
After neoadjuvant chemotherapy in individuals with breast cancer, if sentinel lymph node evaluation is planned	• Lymph system imaging (lymphoscintigraphy, CPT® 78195) ◦ SPECT/CT (CPT® 78830) if requested
ANY of the following in individuals with breast cancer: • Assessing for residual disease after surgery • Assessing response to neoadjuvant chemotherapy • After lumpectomy or mastectomy, prior to adjuvant therapy	• Neither PET nor CT are medically necessary for systemic restaging after neoadjuvant chemotherapy or after surgery • If surgery upstages individual to Stage III N2 disease or higher and has not had prior staging, refer to **Breast Cancer - Initial Work-up/Staging (ONC-11.2)**

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Indication	Medically Necessary Imaging Study
• Treatment response in individuals with metastatic disease and measurable disease on imaging: ◦ For individuals receiving chemotherapy, imaging is medically necessary after every 2 cycles ◦ For individuals receiving hormonal or endocrine therapy, imaging is medically necessary every 3 months	• CT Chest with contrast (CPT® 71260); and CT Abdomen and Pelvis with contrast (CPT® 74177) • Bone scan (CPT® 78306) In addition to the above options, for individuals receiving systemic treatment for brain metastases: • MRI Brain without and with contrast (CPT® 70553)
ANY of the following in individuals with breast cancer: • Elevated LFTs • Elevated tumor markers** (i.e., CA27/29, CA15-3. CEA, alkaline phosphatase) • Signs or symptoms of recurrence • Biopsy proven recurrence	Any or all of the following: • CT Chest with contrast (CPT® 71260); **and** CT Abdomen and Pelvis with contrast (CPT® 74177) • Bone scan (CPT® 78306) For individuals with prior history of brain metastases or current signs or symptoms of brain metastasis: • MRI Brain without and with contrast (CPT® 70553) **Elevated ctDNA alone in the absence of elevations of traditional tumor markers and/or clinical signs and symptoms does not warrant imaging
• Inconclusive CT, MRI, and/or bone scan in individuals with breast cancer • Treatment response assessment for bone-only metastases (excluding brain metastases) and a prior bone scan has not been performed for serial comparison in individuals with breast cancer	• ^{18}F-FDG PET/CT (CPT® 78815 or 78816)

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Indication	Medically Necessary Imaging Study
Individuals with breast cancer with known or suspected bone metastases AND inconclusive bone findings on ALL of the following: • CT, MRI, bone scan, and FDG PET/CT scan	• ^{18}F Sodium Fluoride PET/CT (CPT® 78815 or 78816)
To determine the ER-status of suspected/ known metastatic recurrence in individuals with breast cancer noted on CT/bone scan and any one of the following: • Biopsy of metastatic site is non-diagnostic/inconclusive • Biopsy of metastatic site is risky & cannot be performed (metastatic sites in the brain, spine or near vascular structures)	• ^{18}F-FES (fluoroestradiol) PET/CT scan (CPT® 78815 or CPT® 78816)

Indication	Medically Necessary Imaging Study
Individuals with breast cancer treated with Enhertu® (fam-trastuzumab deruxtecan) in the adjuvant setting	• High-resolution CT Chest without contrast (CPT® 71250) ◦ Baseline if not already done within past 4 weeks ◦ Every 12 weeks while on Enhertu® therapy ▪ For patients receiving Enhertu® concurrent with radiation therapy, an additional scan is medically necessary at the end of radiation at approximately week 6 ◦ End of treatment with Enhertu® (5-7 weeks after last cycle) ◦ For suspected or known ILD, see **Interstitial Lung Disease (ILD)/ Diffuse Lung Disease (DLD) (CH-11.1)** ◦ HRCT (CPT® 71250) can be done per the above criteria if previous diagnostic CT Chest with contrast (CPT® 71260) was not adequate. HRCT is done with a thinner-slice protocol that can provide additional details to help determine ILD subtype.

Background and Supporting Information

Breast cancer recurrence includes local, regional, and distant metastatic disease, each with distinct patterns of presentation and clinical implications. Local recurrence typically occurs in the ipsilateral breast or chest wall, while regional recurrence involves lymph nodes, and distant recurrence reflects metastatic spread to organs such as bone, liver, lung, or brain. Risk of recurrence varies based on tumor biology, stage at diagnosis, and treatment received, with the greatest risk occurring within the first several years following primary therapy (NCCN, 2026).

Evidence Discussion

Breast MRI is supported as a problem-solving tool in restaging and recurrence, particularly when conventional imaging is inconclusive or discordant with clinical findings. Evidence demonstrates that MRI provides improved delineation of tumor

extent and may more accurately estimate size of recurrent disease compared with mammography and ultrasound, particularly in settings such as ipsilateral breast tumor recurrence (Walstra et al., 2020). MRI also improves detection of multifocal disease and can identify additional occult lesions not seen on conventional imaging, which may influence surgical planning (Walstra et al., 2020; Hovis et al., 2021). However, these benefits must be balanced against limitations, including higher false-positive rates and potential for overtreatment or unnecessary biopsies, supporting its selective rather than routine use in recurrence evaluation (Walstra et al., 2020).

Following neoadjuvant chemotherapy, MRI provides the most accurate imaging estimate of residual disease compared with conventional modalities, although it may still overestimate or underestimate tumor size in some cases (Hovis et al., 2021). This supports its use in assessing treatment response and determining surgical resectability. However, the variability in accuracy and absence of consistent outcome benefit with routine use reinforce that imaging should be guided by clinical context rather than performed universally.

Systemic imaging with CT, bone scan, and MRI is primarily supported in individuals with suspected or confirmed metastatic disease. NCCN guidelines support the use of CT chest/abdomen/pelvis and bone scan for evaluation of recurrence when there are symptoms, abnormal laboratory findings, or biopsy-proven disease, as these modalities provide comprehensive assessment of common metastatic sites (NCCN, 2026). Serial imaging during systemic therapy allows for objective assessment of treatment response and progression, enabling timely modification of therapy. However, routine systemic imaging after surgery or neoadjuvant therapy in asymptomatic individuals is not recommended due to low yield and lack of demonstrated survival benefit (ASCO, 2021; NCCN, 2026). This principle extends to circulating tumor DNA (ctDNA). NCCN restricts ctDNA-based biomarker testing to recurrent resectable (local or regional) or stage IV disease for selection of targeted therapy, and does not endorse ctNDA as a trigger for surveillance imaging in earlier-stage or asymptomatic individuals (NCCN, 2026). Accordingly, elevated ctDNA alone, in the absence of elevations of traditional tumor markers and/or clinical signs and symptoms, does not warrant imaging (NCCN, 2026).

Advanced functional imaging with FDG-PET/CT provides whole-body metabolic assessment and may detect disease not seen on conventional imaging, but its routine use in restaging is limited by lack of standardized response criteria and potential for false-positive findings. NCCN recommends PET/CT primarily as a problem-solving tool when conventional imaging is equivocal or inconclusive (NCCN, 2026). Similarly, sodium fluoride PET/CT may be useful in detection of bone metastases when other imaging is nondiagnostic. Overall, the evidence supports a risk-adapted, symptom-driven imaging approach for restaging and recurrence that prioritizes diagnostic accuracy while minimizing unnecessary radiation exposure, cost, and downstream interventions.

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Breast Cancer – Surveillance/Follow-Up (ONC-11.4)

ON.BC.0011.4.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Measurable metastatic disease in individuals with breast cancer on maintenance therapy or being monitored off therapy	ANY or ALL of the following, every 3 months for up to 5 years after completion of active treatment: • CT Chest (CPT® 71260) **and** CT Abdomen and Pelvis (CPT® 74177) with contrast • Bone scan (CPT® 78306)
• Asymptomatic non-metastatic disease in individuals with breast cancer • Individuals receiving post-operative adjuvant therapy in individuals with breast cancer	• No advanced imaging

Oncology Imaging Guidelines

Indication	Medically Necessary Imaging Study
Breast surveillance in an individual with prior history of breast cancer (not treated with bilateral mastectomy) AND any one of the following: • Known high-risk genetic mutations: ◦ Li-Fraumeni Syndrome/TP53 Syndrome ◦ BRCA1 ◦ BRCA2 ◦ Peutz-Jehgers Syndrome (STK11/LKB1 gene variations) ◦ PTEN Mutation/Cowden Syndrome ◦ CDH1 ◦ NF1 ◦ PALB2 ◦ ATM ◦ CHEK2 ◦ NBN ◦ BARD1 ◦ RAD51C ◦ RAD51D • Clinical lifetime risk estimated to be greater than or equal to 20% using genetic or clinical risk estimator as calculated by one of the following models, calculated prior to the initial diagnosis of breast cancer ◦ Gail (National Cancer Institute (NCI)) ◦ Tyrer-Cuzick (International Breast Cancer Intervention Study (IBIS))	• Bilateral MRI Breast without and with contrast (CPT® 77049) annually • See also: **Breast MRI Indications (BR-5.1)**

Indication	Medically Necessary Imaging Study
◦ The Breast Cancer Surveillance Consortium (BCSC) ◦ Breast and Ovarian Analysis of Disease Incidence and Carrier Estimation Algorithm (BOADICEA)/CanRisk ◦ BRCAPRO Model • Dense breast tissue (breast density category C or D) on mammography • Age at diagnosis ≤50 years • Invasive lobular carcinoma (ILC) • Individuals with a prior history of high-risk lesions, including: atypical ductal hyperplasia (ADH), atypical lobular hyperplasia (ALH), or lobular carcinoma in situ (LCIS)	
• Individuals with breast cancer treated with bilateral mastectomy • All other individuals with breast cancer with no high risk features (as stated above)	• Breast MRI is not medically necessary for routine surveillance of asymptomatic individuals

Background and Supporting Information

Breast cancer surveillance following primary treatment focuses on detection of locoregional recurrence, second primary breast cancers, and, in selected patients, monitoring for metastatic progression. Surveillance strategies vary based on initial stage, treatment modality, and individual risk factors, including genetic predisposition, breast density, and age at diagnosis (NCCN, 2026). Routine follow-up typically includes clinical evaluation and annual mammography, while additional imaging is guided by risk stratification and clinical findings.

Evidence Discussion

Routine surveillance imaging in asymptomatic individuals with non-metastatic breast cancer is not supported by evidence demonstrating clinical benefit. NCCN-based recommendations consistently emphasize that intensive imaging, including CT,

PET, or bone scans, does not improve survival or quality of life in this population and is associated with harms such as radiation exposure, false-positive findings, unnecessary biopsies, and increased cost (NCCN, 2026). These findings underpin the recommendation to avoid advanced imaging in asymptomatic individuals receiving adjuvant therapy or in routine follow-up.

Evidence from systematic reviews and meta-analyses further demonstrates the limited utility of imaging surveillance after mastectomy. Detection rates of clinically occult, nonpalpable recurrences are low across all imaging modalities, including MRI, mammography, and ultrasound, and fall below accepted performance benchmarks (Smith et al., 2022). Moreover, interval cancer rates are comparable to or exceed detection rates in some settings, indicating that routine imaging may not meaningfully improve early detection beyond clinical examination. These data support recommendations against routine imaging surveillance in individuals treated with mastectomy.

Breast MRI provides benefit in selected high-risk individuals by improving detection of early-stage and otherwise occult cancers, particularly in patients with dense breast tissue or elevated lifetime risk. MRI has been shown to detect cancers at earlier stages and reduce interval cancer rates in high-risk populations, but its use is associated with increased false-positive findings, additional testing, and potential overdiagnosis (Monticciolo et al., 2023; NCCN, 2026). These competing benefits and harms support restricting MRI surveillance to individuals with clearly defined high-risk features rather than routine use in all breast cancer survivors.

In individuals with measurable metastatic disease, serial imaging with CT and bone scan provides objective assessment of treatment response and progression, which is critical for guiding ongoing therapy. Evidence supports periodic imaging at defined intervals based on treatment type, as this approach enables timely modification of systemic therapy while balancing cumulative radiation exposure (Christin et al., 2019; NCCN, 2026). Overall, the evidence supports a risk-adapted surveillance strategy that limits imaging in asymptomatic non-metastatic patients, incorporates MRI selectively in high-risk populations, and utilizes structured imaging follow-up for patients with known metastatic disease.

Per NCCN recommendations, BRCAPRO, Tyrer-Cuzick, Breast Cancer Surveillance Corsortium (BCSC), and Breast and Ovarian Analysis of Disease Incidence and Carrier Estimation Algorithm (BOADICEA)/CanRisk are appropriate models used to calculate clinical lifetime-risk. NCCN does not endorse proprietary risk calculators (e.g., MyRisk) to determine clinical lifetime risk. However, if the genetic testing portion identifies a gene that does meet the criteria under Genetic Mutations in , those guidelines should be followed (NCCN, 2026).

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Oncology Imaging Guidelines

Sarcomas – Bone, Soft Tissue, and GIST (ONC-12)

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Bone and Soft Tissue Sarcomas – General Considerations (ONC-12.1)

ON.SS.0012.1.A
v1.0.2027

Criteria

- Malignant nerve sheath tumor cell types should be imaged as high-grade sarcoma.
- Sarcomas occur in both adult and pediatric individuals, but some are more common in one age group than the other. Unless specified below, individuals 19 years of age or older should be imaged according to this guideline section.
- Exceptions include:
  - Rhabdomyosarcoma in individuals of all ages should be imaged according to guidelines in **Rhabdomyosarcoma (RMS) (PEDONC-8.2)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
  - Osteogenic sarcoma (Osteosarcoma) in individuals of all ages should be imaged according to guidelines in **Osteogenic Sarcoma (OS) (PEDONC-9.3)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
  - Ewing sarcoma and Primitive Neuroectodermal Tumor in individuals of all ages should be imaged according to guidelines in **Ewing Sarcoma and Primitive Neuroectodermal Tumors (ESFT) (PEDONC-9.4)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
  - Kaposi's sarcoma in individuals of all ages should be imaged according to guidelines in **Kaposi's Sarcoma (ONC-31.10)**.
  - See: **Uterine Cancer (ONC-22)** for imaging recommendations for uterine sarcoma.
  - Desmoplastic small round cell tumor in individuals of all ages should be imaged according to guidelines in **Non-Rhabdomyosarcoma Soft Tissue Sarcomas (NRSTS) (PEDONC-8.3)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

Background and Supporting Information

Bone and soft tissue sarcomas are heterogeneous malignancies of mesenchymal origin that arise in a wide range of anatomic locations, including bone, muscle, fat, nerve sheath, and connective tissues. These tumors demonstrate variable biologic behavior, ranging from low-grade lesions with indolent growth to high-grade aggressive malignancies with metastatic potential. Accurate characterization of tumor grade, size, and anatomic relationships is essential for staging and treatment planning, as these factors significantly influence prognosis and management (NCCN, 2026).

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Evaluation and management of sarcomas require a multidisciplinary approach that includes radiology, surgery, medical oncology, radiation oncology, and pathology. Both NCCN bone and soft tissue sarcoma guidelines emphasize that patients should be treated in specialized centers with expertise in sarcoma care, as coordinated multidisciplinary planning improves diagnostic accuracy and optimizes treatment outcomes (NCCN, 2026).

Evidence Discussion

The choice of imaging modality for sarcoma evaluation is guided by tumor location and clinical scenario, with cross-sectional imaging providing the greatest diagnostic value. MRI is generally preferred for evaluation of the primary tumor because of its superior soft tissue contrast resolution, enabling accurate delineation of tumor extent, involvement of adjacent structures, and surgical planning. CT offers complementary value, particularly for osseous structures and anatomic regions such as the chest and retroperitoneum, where it provides detailed assessment of tumor size and involvement of visceral or vascular structures (NCCN, 2026). The use of these modalities improves staging accuracy and informs treatment decisions, though MRI availability, cost, and patient tolerance may limit universal use.

Cross-sectional imaging also supports accurate biopsy planning and reduces the risk of sampling error or complications. NCCN guidelines emphasize that imaging should be performed prior to biopsy and coordinated with the surgical team to optimize biopsy placement and avoid compromising future resection margins (NCCN, 2026). This approach minimizes adverse outcomes and enhances diagnostic yield but requires careful coordination and may increase upfront complexity of care.

Health Equity Considerations

Soft tissue sarcomas (STS) are rare, heterogeneous malignancies that require timely, coordinated, and highly specialized multidisciplinary care, yet access to such care is not equitable across populations. Diagnostic and treatment delays are common due to nonspecific early symptoms, limited exposure to sarcoma in primary care, and the relative scarcity of specialized sarcoma centers, which are often concentrated in academic or urban settings. These challenges disproportionately affect historically marginalized populations. Large, multi-institutional U.S. data demonstrate that racial and ethnic disparities exist in time to treatment for patients with soft tissue sarcomas, with Black individuals experiencing longer delays to surgical resection and radiation therapy compared with White individuals, particularly in non-emergent care settings (Romoff et al., 2026). Earlier surgical intervention observed among some Black and Hispanic individuals in metastatic or urgent contexts likely reflects more advanced disease at presentation rather than improved access, highlighting inequities upstream in early diagnosis, referral, and imaging-based evaluation (Romoff et al., 22026).

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At the population level, global analyses reveal substantial geographic and sociodemographic disparities in the burden of soft tissue and other extraosseous sarcomas. While high-income regions demonstrate higher incidence and prevalence, likely reflecting better access to diagnostic imaging and pathology, low and low-middle Socio-Demographic Index regions experience higher mortality and disability-adjusted life-year burdens, underscoring inequities in timely diagnosis and access to effective treatment (Zhu et al., 2025). Across regions, males and older adults bear a disproportionately higher disease burden, and resource-limited settings face challenges including inadequate imaging infrastructure, workforce shortages, and incomplete cancer surveillance systems (Zhu et al., 2025). Standardized oncology imaging guidelines play a critical role in promoting health equity by supporting early recognition, appropriate diagnostic workup, accurate staging, and treatment response assessment regardless of care setting. When applied consistently and integrated with improved referral pathways and access to sarcoma-experienced multidisciplinary teams, evidence-based imaging pathways may help reduce disparities in outcomes for individuals with soft tissue sarcomas.

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Soft Tissue Sarcomas – Initial Work-up/ Staging (ONC-12.2)

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Criteria

Indication	Medically Necessary Imaging Study
All individuals	• CT Chest with (CPT® 71260) or CT Chest without (CPT® 71250) contrast • MRI without and with contrast of involved area ◦ CT of involved area if contraindication to MRI
ANY of the following: • Angiosarcoma • Alveolar soft part sarcoma • Clear cell sarcoma • Epithelioid sarcoma • Hemangiopericytoma • Leiomyosarcoma • Liposarcoma • Retroperitoneal or intra-abdominal primary site (including pelvic primary site) • Other histologies documented to have propensity for lymphatic spread and deep-seated tumors	In addition to the above, one of the following combinations: • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast • MRI Abdomen (CPT® 74183) with and without contrast and CT Pelvis (CPT® 72193) with contrast • CT Abdomen (CPT® 74160) with contrast and MRI Pelvis (CPT® 72197) without and with contrast
ANY of the following: • Myxoid round cell liposarcoma • Angiosarcoma • Alveolar soft part sarcoma • Cardiac sarcoma • Neurologic signs or symptoms raising suspicion of CNS metastases	In addition to the above: • MRI Brain without and with contrast (CPT® 70553) • MRI Cervical/Thoracic/Lumbar Spine without and with contrast (CPT® 72156, CPT® 72157, and CPT® 72158)

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Indication	Medically Necessary Imaging Study
Leiomyosarcoma	In addition to the above: • Bone scan (CPT® 78306)
ANY of the following in individuals with soft tissue sarcomas: • Grade of tumor in doubt following biopsy • Conventional imaging suggests solitary metastasis amenable to surgical resection • Inconclusive conventional imaging • Prior to planned neoadjuvant therapy	• PET/CT (CPT® 78815 or CPT® 78816)
Desmoid Tumors	ONE of the following: • CT without contrast or with contrast of the affected body part • MRI without contrast or without and with contrast of the affected body part • Imaging of lung, lymph node, and metastatic site for these tumors is not considered medically necessary
Myxoid/round cell liposarcoma	In addition to the above studies, whole-body MRI (CPT® 76498) is considered medically necessary for a baseline assessment
Dermatofibrosarcoma Protuberans (DFSP)	ONE of the following: • CT without contrast or with contrast of the affected body part • MRI without contrast or without and with contrast of the affected body part • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast for: ◦ Pulmonary symptoms ◦ Abnormal chest x-ray ◦ Sarcomatous differentiation

Indication	Medically Necessary Imaging Study
Malignant phyllodes tumor of the breast (not benign or borderline)	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Breast bilateral without and with contrast (CPT® 77049)

Background and Supporting Information

Soft tissue sarcomas are a heterogeneous group of malignant tumors arising from mesenchymal tissues, including muscle, fat, fibrous tissue, and neurovascular structures. These tumors vary widely in biologic behavior, ranging from low-grade lesions with limited metastatic potential to high-grade tumors with aggressive local invasion and early dissemination. Prognosis and treatment decisions are influenced by tumor size, depth, grade, and histologic subtype, making accurate initial staging essential (NCCN, 2026).

Evidence Discussion

Cross-sectional imaging with MRI or CT of the primary site is strongly supported because it provides accurate delineation of tumor extent, which is critical for staging and surgical planning. MRI, in particular, has demonstrated high sensitivity for distinguishing tumor from surrounding tissues and identifying involvement of adjacent structures, thereby reducing the risk of incomplete resection and improving local control (Noebauer-Huhmann et al., 2020). While CT serves as an alternative when MRI is contraindicated, reliance on MRI when feasible optimizes diagnostic accuracy without exposing patients to ionizing radiation.

CT imaging of the chest is essential for staging due to the high prevalence of pulmonary metastases in soft tissue sarcomas. Early identification of lung metastases directly impacts treatment decisions, including eligibility for surgical resection, systemic therapy, or palliative approaches. Evidence supports the use of a single-phase CT rather than multiple phases, as additional imaging does not significantly improve diagnostic yield but increases radiation exposure, reinforcing a strategy that balances diagnostic accuracy with harm reduction (NCCN, 2026).

Histology-directed and risk-adapted imaging strategies are supported by evidence demonstrating variability in metastatic patterns among sarcoma subtypes. Certain histologies, such as those with propensity for lymphatic or intra-abdominal spread, benefit from additional cross-sectional imaging of the abdomen and pelvis, while routine imaging beyond the chest is not necessary for most extremity or superficial tumors. This

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selective approach minimizes unnecessary imaging, reduces false-positive findings, and avoids additional procedures and patient anxiety (NCCN, 2026).

The selective use of advanced imaging modalities such as FDG-PET/CT is supported in specific clinical scenarios, including indeterminate tumor grade, inconclusive conventional imaging, or evaluation of suspected limited metastatic disease amenable to local therapy. PET/CT can improve detection of metabolically active disease and assist in treatment planning; however, its routine use is limited by cost, variability in specificity, and potential for false-positive results (Kelly et al., 2021). Overall, the evidence supports a tailored imaging strategy that prioritizes MRI for local staging, CT chest for metastatic evaluation, and selective adjunct imaging to maximize diagnostic value while minimizing unnecessary harms.

Oncology Imaging Guidelines

Soft Tissue Sarcomas – Restaging/ Recurrence (ONC-12.3)

ON.SS.0012.3.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
ANY of the following in individuals with soft tissue sarcomas: • After preoperative radiotherapy • After surgical resection	• MRI without and with contrast or CT with contrast of affected body area • CT Chest with contrast (CPT® 71260) OR without contrast (CPT® 71250) (if the primary site is the chest, MRI Chest without and with contrast (CPT® 71552) or MRI Chest with contrast CPT® 71550))
Baseline end of therapy evaluation, including completion of adjuvant radiotherapy in individuals with soft tissue sarcomas	• Same studies as initial work-up (See **Soft Tissue Sarcomas - Initial Work-up/Staging (ONC-12.2)**)
ANY of the following in individuals with soft tissue sarcomas: • Differentiate tumor from radiation or surgical fibrosis • Determine response to neoadjuvant therapy • Confirm oligometastatic disease prior to curative intent surgical resection	• PET/CT (CPT® 78815 or CPT® 78816) ◦ If treated with radiation therapy, PET/CT no sooner than 12 weeks (3 months) post completion of radiation therapy

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Indication	Medically Necessary Imaging Study
EITHER of the following in individuals with soft tissue sarcomas: • Chemotherapy response for individuals with measurable disease • Individuals on neoadjuvant treatment without known lung involvement	• CT with contrast or MRI without and with contrast of affected body area every 2 cycles
Unresectable or metastatic disease on chemotherapy in individuals with soft tissue sarcomas	Every 2 cycles: • CT with contrast or MRI without and with contrast of affected body area AND • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250)
Recurrence suspected in individuals with soft tissue sarcomas	• Repeat all imaging for initial workup of specific histology and/or primary site and other symptomatic areas (See **Soft Tissue Sarcomas - Initial Work-up/ Staging (ONC-12.2)**)
Preoperative planning prior to resection in individuals with soft tissue sarcomas	ANY or ALL of the following: • MRI without contrast or without and with contrast of involved area • CT (contrast as requested) of involved area
Dermatofibrosarcoma Protuberans (DFSP)	• CT without contrast or with contrast of the affected body part or MRI without contrast or without and with contrast of the affected body part • CT Chest with contrast (CPT® 71260) or CT Chest without (CPT® 71250) contrast for: ◦ Known prior thoracic disease ◦ New or worsening pulmonary symptoms ◦ New or worsening chest x-ray ◦ Sarcomatous differentiation

Indication	Medically Necessary Imaging Study
Malignant phyllodes tumor of the breast (not benign or borderline) after resection or radiotherapy	See **Soft Tissue Sarcomas - Surveillance/Follow-up (ONC-12.4)**
Diffuse tenosynovial giant cell tumors	• MRI of the affected site every 6-12 months for individuals with symptomatic disease but not on active therapy • For individuals on active therapy, MRI of the affected site every 3-4 months

Background and Supporting Information

Soft tissue sarcomas encompass a diverse group of mesenchymal tumors with varying risks of local recurrence and metastatic spread based on histologic subtype, tumor grade, and adequacy of initial treatment. Following definitive therapy, recurrence may occur locally at the primary site or distantly, most commonly in the lungs, necessitating a structured imaging approach for restaging and treatment response assessment (NCCN, 2026).

Local recurrence is influenced by tumor biology and completeness of surgical resection. For example, dermatofibrosarcoma protuberans (DFSP), a low-grade soft tissue sarcoma, demonstrates a high propensity for local recurrence due to subclinical extensions, while metastatic spread is uncommon but can occur in advanced or transformed disease (NCCN, 2026). These patterns highlight the importance of accurate imaging to differentiate post-treatment changes from recurrent disease and guide management decisions.

Evidence Discussion

Cross-sectional imaging of the primary site with MRI or CT following preoperative radiotherapy or surgical resection is supported because of its ability to accurately evaluate treatment response, residual disease, and early recurrence. MRI is particularly valuable for differentiating tumor recurrence from post-treatment fibrosis or scarring due to its superior soft tissue contrast, while CT provides an alternative when MRI is contraindicated. This approach improves detection of clinically relevant disease while minimizing unnecessary procedures (Noebauer-Huhmann et al., 2020; NCCN, 2026).

Routine inclusion of chest imaging is supported in most restaging scenarios due to the high incidence of pulmonary metastases across many soft tissue sarcoma subtypes. However, evidence and NCCN guidance indicate that in the absence of known lung involvement or symptoms, frequent restaging of the chest during active treatment

provides limited additional benefit and increases radiation exposure and the risk of incidental findings. This supports a more selective, risk-adapted approach to thoracic imaging (NCCN, 2026).

PET/CT is supported as an adjunct tool in specific clinical scenarios, including differentiating recurrent tumor from post-treatment changes, assessing response to neoadjuvant therapy, and confirming limited metastatic disease prior to curative-intent resection. Evidence suggests that metabolic parameters such as changes in tumor FDG uptake can predict recurrence risk and treatment response, thereby informing clinical decision-making. However, PET/CT is not routinely required due to cost, limited specificity, and potential false-positive findings, reinforcing its role as a problem-solving modality (NCCN, 2026).

Serial imaging during systemic or neoadjuvant therapy, typically every two treatment cycles, is considered medically necessary to assess treatment response and guide ongoing management. This interval balances the need for timely identification of progression with minimizing cumulative radiation exposure. Overall, the evidence supports a tailored imaging strategy that prioritizes modality selection based on tumor biology, treatment phase, and clinical scenario, optimizing diagnostic accuracy while limiting harms such as radiation exposure, false-positive findings, and unnecessary downstream interventions (NCCN, 2026; Noebauer-Huhmann et al., 2020).

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Soft Tissue Sarcomas - Surveillance/ Follow-up (ONC-12.4)

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v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
For any of the following: • Retroperitoneal/intra-abdominal primary site (including pelvic primary site) in individuals with soft tissue sarcomas • Angiosarcoma • Epithelioid sarcoma	ANY or ALL of the following every 3 months for 3 years, then every 6 months for 2 more years, then annually: • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast • CT Abdomen and Pelvis with contrast (CPT® 74177) OR MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) • CT with contrast or MRI without and with contrast of any other involved body areas
Myxoid/round cell liposarcoma	ANY or ALL of the following every 3 months for 2 years, then every 6 months for 2 more years, then annually: • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast • CT Abdomen and Pelvis with contrast (CPT® 74177) OR MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) • CT with contrast or MRI without and with contrast of any other involved body areas • MRI Cervical/Thoracic/Lumbar Spine without and with contrast (CPT® 72156, CPT® 72157, and CPT® 72158)

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Indication	Medically Necessary Imaging Study
Low-grade/Stage I extremity or trunk, primary site in individuals with soft tissue sarcomas	ANY or ALL of the following every 6 months for 2 years, then annually thereafter: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • CT with contrast, MRI without contrast, or MRI without and with contrast of primary site
Any soft tissue sarcoma not addressed elsewhere in these surveillance guidelines	ANY or ALL of the following every 3 months for 2 years, then every 6 months for 2 more years, then annually: • CT with contrast, MRI without contrast, or MRI without and with contrast of primary site • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast • CT with contrast or MRI without and with contrast of any other involved body areas
ANY of the following: • Angiosarcoma • Alveolar soft part sarcoma • Cardiac sarcoma	In addition to the above studies (CT or MRI of primary site and any other involved body areas, CT Chest): • MRI Brain without and with contrast (CPT® 70553) annually For surveillance of individuals with known brain metastases, see: **Brain Metastases (ONC-31.3)**
Desmoid tumors	ONE of the following every 3 months for 3 years, then every 6-12 months: • CT without contrast or with contrast of the affected body part • MRI without contrast or without and with contrast of the affected body part
Dermatofibrosarcoma Protuberans	• No routine imaging unless clinical signs/symptoms of recurrence

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Indication	Medically Necessary Imaging Study
Malignant phyllodes tumor of the breast (not borderline or benign)	ANY or ALL of the following every 3-6 months for 3 years, then every 6 months for 2 years, and then annually • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Breast bilateral without and with contrast (CPT® 77049)
Completely resected tenosynovial giant cell tumors and/or asymptomatic diffuse tenosynovial giant cell tumors not on systemic therapy	Advanced imaging is only considered medically necessary for restaging and/or suspected recurrence/ progression • No further advanced imaging is considered medically necessary for asymptomatic individuals who are not on active therapy

Background and Supporting Information

Soft tissue sarcomas are a heterogeneous group of malignancies with variable risks of local recurrence and distant metastasis that are strongly influenced by tumor grade, size, depth, and histologic subtype. Patterns of recurrence differ significantly across subtypes, with many sarcomas demonstrating a predilection for pulmonary metastases, while others more commonly recur locally or involve extrapulmonary sites such as the abdomen, spine, or brain (NCCN, 2026).

These biologic differences form the basis for risk-adapted surveillance strategies. Local recurrence is particularly influenced by surgical margins and tumor biology, while distant recurrence, most commonly in the lungs, reflects hematogenous spread. Certain subtypes, such as myxoid/round cell liposarcoma, may metastasize to atypical locations including the spine, while others such as angiosarcoma may involve the brain (NCCN, 2026; Noebauer-Huhmann et al., 2020).

Evidence Discussion

Surveillance imaging strategies are supported by evidence demonstrating that recurrence patterns in soft tissue sarcomas are histology-specific, justifying tailored imaging intervals and modalities. NCCN recommendations for more intensive surveillance during the first 2–3 years after treatment reflect the higher likelihood of recurrence during this period, with gradual de-escalation over time as recurrence risk declines (NCCN, 2026). This approach improves early detection of clinically significant recurrence while avoiding prolonged exposure to unnecessary imaging.

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Imaging of the chest is a cornerstone of surveillance due to the high incidence of pulmonary metastases across most soft tissue sarcoma subtypes. CT is favored due to its sensitivity for detecting small lung lesions that may be amenable to surgical resection or systemic therapy. However, the frequency and duration of chest imaging are adjusted based on tumor risk, balancing early detection with cumulative radiation exposure and cost (NCCN, 2026).

Cross-sectional imaging of the primary site with MRI or CT is supported for detecting local recurrence, particularly in higher-risk or deep-seated tumors. MRI is especially valuable for differentiating recurrent tumor from post-treatment changes such as fibrosis due to its superior tissue characterization. This reduces diagnostic uncertainty and limits unnecessary biopsies or interventions, though repeated imaging carries potential risks of cost and, in the case of CT, radiation exposure (Noebauer-Huhmann et al., 2020).

Evidence also supports limiting imaging intensity in lower-risk populations. A randomized noninferiority trial demonstrated that less intensive surveillance did not result in worse survival outcomes compared with more frequent imaging, suggesting that excessive surveillance may not improve outcomes while increasing harms such as radiation exposure, false-positive findings, and downstream procedures (Puri et al., 2014). Additionally, PET/CT is not recommended for routine asymptomatic surveillance due to lack of demonstrated benefit and increased risk of false-positive findings and unnecessary interventions (NCCN, 2026). Collectively, these data support a risk-adapted surveillance strategy that aligns imaging intensity with tumor biology, maximizing clinical benefit while minimizing harms.

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Gastrointestinal Stromal Tumor (GIST) (ONC-12.5)

ON.SS.0012.5.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Suspected/Diagnosis of GIST	• CT Abdomen and Pelvis with contrast (CPT® 74177)
Initial Work-up/Staging of GIST	• CT Chest (CPT® 71260) with contrast or CT Chest without contrast (71250) and • CT Abdomen and Pelvis (CPT® 74177) with contrast, if not already performed
In addition to the above imaging for initial staging of either of the following in individuals with GIST: • Liver lesions noted on initial CT • Preoperative assessment of liver	• MRI Abdomen without and with contrast (CPT® 74183)
Monitoring response to treatment (every 8 to 12 weeks) in any of the following in individuals with GIST: • Unresectable primary disease • Metastatic disease • Resectable disease with significant morbidity	EITHER of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Additional treatment response, in addition to the above imaging, for known or suspected chest involvement in individuals with GIST	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250)
Evaluation of inconclusive findings on conventional imaging in individuals with GIST	• PET/CT (CPT® 78815)

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Indication	Medically Necessary Imaging Study
Surveillance for any of the following in individuals with GIST: • Incompletely resected • Metastatic disease • High-risk disease	Every 3 months for 5 years, then annually: • CT Abdomen and Pelvis with contrast (CPT® 74177)
Surveillance for completely resected, low-risk disease in individuals with GIST	Every 6 months for 5 years, then annually: • CT Abdomen and Pelvis with contrast (CPT® 74177)
Known or suspected recurrence in individuals with GIST	ANY or ALL of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) for known or suspected liver involvement • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) for known or suspected chest involvement

Background and Supporting Information

Gastrointestinal stromal tumors (GIST) are the most common mesenchymal tumors of the gastrointestinal tract and arise most frequently in the stomach and small intestine. They are driven primarily by activating mutations in the KIT or PDGFRA genes and exhibit a wide spectrum of biologic behavior, ranging from indolent lesions to aggressive malignancies with metastatic potential. The liver and peritoneal surfaces are the most common sites of metastatic spread, while lymph node and extra-abdominal metastases are uncommon except in advanced disease (NCCN, 2026).

Risk stratification in GIST is estimated by a prognostic model based on location, size of primary tumor, and mitotic rate per high power field (HPF), which together predict the likelihood of recurrence and guide treatment decisions. Larger tumor size and higher mitotic activity are associated with increased malignant potential and recurrence risk, with high-risk tumors requiring more intensive surveillance and systemic therapy considerations. The high-risk category includes any tumor >5cm with >5 mitoses/50 HPF and any tumors >10cm in size regardless of mitotic rate (NCCN, 2026).

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Evidence Discussion

CT of the abdomen and pelvis with contrast is the primary imaging modality for diagnosis and staging due to its high sensitivity for detecting primary tumors and metastatic disease, particularly in the liver and peritoneum. NCCN guidelines identify contrast-enhanced CT as the imaging modality of choice for characterizing abdominal masses and evaluating disease extent, providing comprehensive anatomic detail necessary for staging and treatment planning. Limiting advanced imaging prior to confirmed diagnosis helps reduce unnecessary radiation exposure and incidental findings without compromising diagnostic accuracy (NCCN, 2026).

MRI serves as an important adjunct in selected scenarios, particularly for evaluation of indeterminate liver lesions or preoperative assessment of hepatic involvement. MRI provides superior soft tissue contrast and more precise characterization of liver metastases, complementing CT findings and improving diagnostic confidence in complex cases. This selective use balances improved lesion characterization with considerations of cost and resource utilization (NCCN, 2026).

For treatment response assessment, serial imaging with CT or MRI every 8–12 weeks is supported by evidence demonstrating that this interval aligns with the expected therapeutic response timeframe for TKI therapy. NCCN notes a high correlation between contrast-enhanced CT and PET/CT findings, supporting CT as the preferred routine modality for monitoring response while avoiding additional radiation exposure and cost associated with PET/CT. More frequent imaging may lead to premature or inaccurate treatment decisions, while less frequent imaging may delay identification of disease progression (NCCN, 2026).

PET/CT provides functional assessment and may detect early metabolic changes that precede anatomic response, making it useful in specific clinical scenarios such as inconclusive conventional imaging or early evaluation of treatment efficacy. However, PET/CT is not a substitute for diagnostic CT and is not recommended for routine use due to limited additional benefit, potential false-positive findings, and increased cost (NCCN, 2026).

Surveillance strategies are risk-adapted, with more frequent imaging for high-risk, incompletely resected, or metastatic disease and less frequent imaging for low-risk tumors. NCCN supports imaging every 3–6 months for the first five years, when recurrence risk is highest, followed by less frequent imaging thereafter. This approach maximizes early detection of recurrence while minimizing cumulative radiation exposure, unnecessary imaging, and downstream interventions (NCCN, 2026).

Health Equity Considerations

Gastrointestinal stromal tumors (GIST) are rare mesenchymal neoplasms that require timely imaging, molecular characterization, and multidisciplinary care to guide surgical

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and systemic treatment. As with other rare cancers, disparities in access to specialized expertise, advanced imaging, and molecular testing can meaningfully influence outcomes. Population-level studies of rare malignancies demonstrate that patients who are uninsured, underinsured, or residing in socioeconomically disadvantaged or rural settings are more likely to experience delays in diagnosis and treatment, contributing to larger tumor size and higher risk features at presentation (Hu et al., 2022). Because risk stratification and treatment planning in GIST rely heavily on cross-sectional imaging for tumor localization, staging, and assessment of treatment response, inequities in access to high-quality imaging and subspecialty interpretation may disproportionately affect underserved populations. Limited access to specialty centers with sarcoma expertise may further compound disparities, as GIST management often requires coordination across surgical oncology, medical oncology, pathology, and radiology services.

Globally, structural differences in health-care infrastructure and access to specialized cancer services further accentuate inequities in the diagnosis and management of rare tumors such as GIST. International surveys of sarcoma care consistently report lower availability of advanced imaging modalities, molecular diagnostics, and coordinated multidisciplinary pathways in low- and middle-income regions, with corresponding delays in referral and treatment initiation (Zamora et al., 2025). These inequities may limit appropriate risk assessment, delay initiation of targeted therapy, and hinder optimal surveillance strategies. Standardized, evidence-based oncology imaging guidelines play a key role in promoting health equity by supporting consistent diagnostic evaluation, staging, and follow-up across diverse care settings. When combined with timely referral to experienced centers and efforts to reduce financial and geographic barriers, guideline-concordant imaging pathways can help mitigate disparities and improve outcomes for patients with gastrointestinal stromal tumors.

Oncology Imaging Guidelines

Bone Sarcomas - Initial Work-Up/Staging (ONC-12.6)

ON.SS.0012.6.C
v1.0.2027

Criteria

- Osteogenic sarcoma (Osteosarcoma) in individuals of all ages should be imaged according to guidelines in **Osteogenic Sarcoma (OS) (PEDONC-9.3)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
- Ewing sarcoma and Primitive Neuroectodermal Tumor in individuals of all ages should be imaged according to guidelines in **Ewing's Sarcoma Family of Tumors (PEDONC-9.4)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
- Extraskeletal myxoid chondro sarcoma in individuals of all ages should be imaged according to Soft Tissue Sarcomas (ONC-12.2, ONC-12.3, and ONC-12.4).
- Bone sarcomas not addressed in this guideline are exceedingly rare and will be evaluated on a case-by-case basis.

Indication	Medically Necessary Imaging Study
Chondrosarcoma • Low-grade intra-compartmental • High-grade (grade II or grade III) • Clear cell • Extra-compartmental	ANY or ALL of the following: • MRI without contrast or without and with contrast of involved area • CT (contrast as requested) of involved area • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast
Dedifferentiated chondrosarcoma	See: **Osteogenic Sarcoma (OS) (PEDONC-9.3)** for imaging
Mesenchymal chondrosarcoma	See: **Ewing's Sarcoma Family of Tumors (PEDONC-9.4)** for imaging

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Indication	Medically Necessary Imaging Study
Chordoma	ANY or ALL of the following: • MRI without contrast or without and with contrast of involved area • CT (contrast as requested) of involved area • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Cervical (CPT® 72156), Thoracic (CPT® 72157), and Lumbar (CPT® 72158) Spine without and with contrast • Bone scan (CPT® 78306)
Chordoma with inconclusive findings on conventional imaging	PET/CT (CPT® 78815 or CPT® 78816)

Background and Supporting Information

Bone sarcomas are malignant tumors arising from osseous tissues and include multiple histologic subtypes with distinct biologic behaviors and patterns of spread. Imaging plays a central role in initial work-up and staging by defining local tumor extent, identifying metastatic disease, and guiding multidisciplinary treatment planning. Prognosis is influenced by tumor grade, size, anatomic location, and presence of metastases, making comprehensive staging essential at diagnosis (NCCN, 2026).

Evidence Discussion

Cross-sectional imaging of the primary site with MRI or CT is supported as it provides optimal delineation of tumor extent and local staging. MRI is particularly advantageous for assessing marrow involvement, soft tissue extension, and neurovascular encasement, while CT is useful for characterizing cortical bone destruction and mineralized matrix. The ability to select either modality allows clinicians to tailor imaging to tumor location and patient-specific considerations, optimizing diagnostic accuracy while minimizing unnecessary radiation exposure (NCCN, 2026).

CT of the chest is essential for staging due to the high incidence of pulmonary metastases in malignant bone sarcomas. Evidence supports CT as the most sensitive modality for detecting lung metastases, directly influencing staging and management decisions. Importantly, performing CT with both contrast and noncontrast phases does not provide additional clinical benefit and results in increased radiation exposure, supporting the use of a single-phase CT approach (NCCN, 2026).

For chordoma, a broader imaging strategy is supported due to its unique biologic behavior and propensity for axial and distant spread. Imaging of the abdomen and pelvis with contrast, along with MRI of the entire spine and bone scan, improves detection of metastatic or multifocal disease that may not be identified with more limited imaging. While this expanded imaging increases diagnostic yield, it must be balanced against increased cost and exposure, reinforcing its indication specifically for this histology rather than routine use across all bone sarcomas (NCCN, 2026).

PET/CT is supported as a problem-solving modality when conventional imaging is inconclusive. Although PET/CT can provide functional assessment and improve detection of metabolically active disease, its routine use in initial staging is not recommended due to limited sensitivity and specificity compared with standard imaging modalities and the potential for false-positive findings. Restricting PET/CT to select scenarios minimizes unnecessary costs, radiation exposure, and downstream interventions while maintaining diagnostic accuracy (NCCN, 2026).

Health Equity Considerations

Bone sarcomas are rare, aggressive malignancies that require early recognition, advanced imaging, biopsy planning, and timely management within specialized multidisciplinary sarcoma centers to optimize outcomes. However, access to high-quality diagnostic and treatment services is unevenly distributed, resulting in meaningful disparities across socioeconomic, racial, and geographic lines. In the United States, population-based analyses demonstrate that insurance status is strongly associated with stage at diagnosis, treatment receipt, and outcomes. Individuals who are uninsured or covered by Medicaid are significantly more likely to present with metastatic disease at diagnosis compared with insured individuals, reflecting delayed access to diagnostic imaging and specialty care (Hu et al., 2022). In addition, Black and Asian/Pacific Islander individuals are less likely to undergo definitive surgical resection, and Black individuals are less likely to receive chemotherapy, even after adjustment for tumor and demographic factors, highlighting inequities in access to guideline-concordant multimodality treatment (Hu et al., 2022). These disparities are particularly impactful for bone sarcomas, where survival is highly dependent on timely imaging-guided diagnosis, surgical management, and coordinated systemic therapy.

Globally, disparities in bone sarcoma care are further amplified by limited access to specialized sarcoma services and advanced imaging technologies. A multinational survey of orthopaedic oncologists found that fewer than half of individuals worldwide are treated primarily in specialized sarcoma centers, with markedly lower access in low- and middle-income countries (Zamora et al., 2025). Respondents from these regions reported frequent treatment delays, compromised surgical management due to prior inappropriate procedures, and inconsistent access to advanced imaging modalities such as PET-CT and molecular diagnostic studies, all of which are critical for accurate staging and treatment planning (Zamora et al., 2025). These structural inequities contribute

to later presentation, suboptimal imaging-based evaluation, and worse outcomes. Standardized, evidence-based oncology imaging guidelines are therefore essential to promoting equitable care by supporting consistent diagnostic pathways, appropriate staging, and treatment response assessment across diverse health-care settings. When combined with timely referral to experienced sarcoma centers and efforts to reduce insurance- and resource-based barriers, guideline-concordant imaging can help mitigate disparities and improve outcomes for individuals with bone sarcomas.

Oncology Imaging Guidelines

Bone Sarcomas - Restaging/Recurrence (ONC-12.7)

ON.SS.0012.7.C
v1.0.2027

Criteria

- Bone sarcomas not addressed in this guideline are exceedingly rare and will be evaluated on a case-by-case basis.

Indication	Medically Necessary Imaging Study
Chondrosarcoma • Low-grade intra-compartmental • High-grade (grade II or grade III) • Clear cell • Extra-compartmental	ANY or ALL of the following, after completion of radiotherapy or every 2 cycles of chemotherapy: • MRI without contrast or without and with contrast of involved area • CT (contrast as requested) of involved area • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast
Suspected recurrence of atypical cartilaginous tumor (low-grade intra-compartmental appendicular tumor)	ANY or ALL of the following: • MRI without contrast or without and with contrast of involved area of CT (contrast as requested) of involved area • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast • Bone scan (CPT® 78306)
Dedifferentiated chondrosarcoma	See: **Osteogenic Sarcoma (OS) (PEDONC-9.3)** for imaging recommendations
Mesenchymal chondrosarcoma	See: **Ewing's Sarcoma Family of Tumors (PEDONC-9.4)** for imaging recommendations
Chordoma	ANY or ALL of the following, after completion of radiotherapy or every 2 cycles of chemotherapy: • MRI without contrast or without and with contrast of involved area • CT (contrast as requested) of involved area • Bone scan (CPT® 78306)

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Indication	Medically Necessary Imaging Study
Chordoma with inconclusive findings on conventional imaging	PET/CT (CPT® 78306 OR CPT® 78816)

Background and Supporting Information

Bone sarcomas represent a group of malignant tumors of osseous origin with variable biologic behavior and recurrence risk depending on histologic subtype, grade, and adequacy of treatment. Following definitive therapy, recurrence may occur locally at the primary site or distantly, most commonly in the lungs due to hematogenous spread. Imaging plays a central role in restaging to assess treatment response, detect recurrence, and guide further management (NCCN, 2026).

Patterns of recurrence differ by tumor subtype and grade. Chondrosarcoma subtypes range from low-grade tumors with limited metastatic potential to high-grade lesions with a higher risk of distant spread, particularly to the lungs. Chordomas, in contrast, demonstrate locally aggressive behavior with potential for distant metastases, including spread along the axial skeleton, necessitating tailored imaging strategies (NCCN, 2026).

Evidence Discussion

MRI or CT of the primary tumor site following treatment is supported for evaluating local recurrence and treatment response. MRI provides superior soft tissue contrast and allows differentiation between residual or recurrent tumor and post-treatment changes, such as fibrosis or necrosis. CT serves as an alternative modality when MRI is contraindicated or when osseous detail is required for assessing cortical involvement. This dual-modality approach improves diagnostic accuracy while allowing flexibility based on patient and tumor characteristics (NCCN, 2026).

CT Chest imaging is essential for restaging due to the high incidence of pulmonary metastases in bone sarcomas. Evidence supports CT as the most sensitive modality for detecting lung metastases, which directly impacts prognosis and management decisions. Routine inclusion of chest imaging ensures early detection of metastatic disease; however, restricting imaging to a single-phase CT reduces radiation exposure without compromising diagnostic yield (NCCN, 2026).

For atypical cartilaginous tumors and selected low-grade lesions with suspected recurrence, the addition of bone scan is supported to evaluate for osseous metastases or multifocal disease. While bone scan increases sensitivity for detecting skeletal involvement, its use is reserved for specific clinical scenarios to limit false-positive

findings and unnecessary downstream testing. This selective approach balances improved detection with avoidance of overimaging (NCCN, 2026).

Advanced imaging such as PET/CT is not routinely recommended for restaging but may be useful when conventional imaging is inconclusive. PET/CT provides metabolic information that can help distinguish viable tumor from post-treatment changes and clarify indeterminate findings. However, limitations in sensitivity and specificity, along with potential for false-positive results, support its role as a problem-solving modality rather than routine imaging, minimizing unnecessary radiation exposure and cost (NCCN, 2026).

Oncology Imaging Guidelines

Bone Sarcomas – Surveillance/Follow-up (ONC-12.8)

ON.SS.0012.8.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
• Intra-compartmental Chondrosarcoma	ANY or ALL of the following every 6-12 months for 2 years, then annually for 10 years: • Plain x-ray of primary site ◦ MRI without and with contrast for new findings on plain x-ray or new/worsening clinical symptoms • Chest x-ray ◦ CT Chest with (CPT® 71260) or without (CPT® 71250) contrast for new findings on chest x-ray, or new/ worsening signs/symptoms
• Grade I, II, or III Chondrosarcoma • Clear Cell Chondrosarcoma • Extra-compartmental Chondrosarcoma • Low-grade extra-compartmental appendicular tumors	ANY or ALL of the following every 6 months for 5 years, then annually for 10 years: • Plain x-ray of primary site ◦ MRI without and with contrast for new findings on plain x-ray or new/worsening clinical symptoms • CT Chest with (CPT® 71260) **or** CT Chest without (CPT® 71250) contrast
Dedifferentiated chondrosarcoma	See: **Osteogenic Sarcoma (OS) (PEDONC-9.3)** for imaging recommendations
Mesenchymal chondrosarcoma	See: **Ewing's Sarcoma Family of Tumors (PEDONC-9.4)** for imaging recommendations

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Indication	Medically Necessary Imaging Study
Chordoma	• Plain x-ray of primary site every 6 months for 5 years and then annually until year 10 ◦ MRI without and with contrast for new findings on plain x-ray or new/worsening clinical symptoms. • Chest x-ray every 6 months for 5 years and then annually until year 10 ◦ CT Chest with (CPT® 71260) or without (CPT® 71250) contrast annually or for evaluation of any new findings on chest x-ray or new/worsening signs/symptoms

Background and Supporting Information

Bone sarcomas are malignant tumors of osseous origin with variable biologic behavior and risk of recurrence depending on histologic subtype, grade, and adequacy of initial treatment. Following definitive therapy, the risk of recurrence is highest within the first several years, with the majority of relapses occurring in the lungs or at the primary site. Surveillance strategies are therefore designed to detect potentially treatable local and metastatic recurrence during this high-risk period (NCCN, 2026).

Patterns of recurrence vary across subtypes. Chondrosarcomas may recur locally or metastasize depending on grade and extent, while chordomas are characterized by local aggressiveness and potential for distant spread, particularly along the axial skeleton. These variations in tumor biology inform surveillance imaging strategies, including modality selection and follow-up intervals (NCCN, 2026).

Evidence Discussion

Surveillance imaging strategies in bone sarcoma are supported by evidence demonstrating limited clinical benefit from routine advanced imaging in asymptomatic individuals. Studies indicate that less than 20% of local recurrences are detected through advanced imaging alone in the absence of symptoms, suggesting that routine use of high-intensity imaging may not significantly improve early detection. This supports the use of plain radiography as the primary modality for local surveillance, reserving MRI for cases with abnormal findings or clinical concern (NCCN, 2026).

Chest imaging is an essential component of surveillance given the predilection for pulmonary metastases. Evidence supports the use of chest radiography or CT based on tumor grade and clinical context, with higher sensitivity observed in higher-grade disease. CT provides greater sensitivity for small pulmonary nodules, but its use is often reserved for abnormal chest radiograph findings or clinical suspicion to minimize cumulative radiation exposure (NCCN, 2026).

Risk-adapted surveillance intervals are supported by recurrence patterns, with more frequent imaging in the first several years after treatment and decreasing frequency over time. This approach maximizes detection of recurrence during periods of highest risk while reducing unnecessary imaging in later years when recurrence becomes less likely. Evidence suggests that recurrence beyond 10 years is rare, and continued routine surveillance imaging in asymptomatic patients beyond this period yields limited clinical benefit while increasing costs and potential harms (NCCN, 2026).

Overall, the evidence supports a conservative, risk-adapted surveillance strategy that emphasizes the use of low-radiation modalities such as plain radiographs and selective use of advanced imaging based on clinical findings. This approach balances early detection of recurrence with minimization of radiation exposure, false-positive findings, and downstream interventions, aligning imaging intensity with both tumor biology and patient risk (NCCN, 2026).

Oncology Imaging Guidelines

Benign Bone Tumors – General Considerations (ONC-12.9)

ON.SS.0012.9.A
v1.0.2027

Criteria

- Plain x-ray appearance is diagnostic for many benign bone tumors and advanced imaging is generally not considered medically necessary except for preoperative planning.
- MRI without and with contrast is the primary modality for advanced imaging of bone tumors and is considered medically necessary to help narrow differential diagnoses and determine whether biopsy is indicated.
- Some benign bone tumor types carry a risk of malignant degeneration over time, but routine advanced imaging surveillance has not been shown to improve outcomes for these individuals.
- MRI without and with contrast is considered medically necessary to evaluate new findings on plain x-ray new/worsening clinical symptoms not explained by a recent plain x-ray.
- There are no data to support the use of PET/CT in the evaluation of benign bone tumors, and PET requests are not considered medically necessary without biopsy confirmation of a malignancy.
- Other benign bone tumors should be imaged according to guidelines in **Bone Lesion (MS-10.2)** in the General Musculoskeletal Imaging Guidelines or **Mass Involving Bone (including Lytic and Blastic Metastatic Disease) (PEDMS-3.4)** in the Pediatric Musculoskeletal Imaging Guidelines.

Background and Supporting Information

Benign bone tumors represent a diverse group of nonmalignant osseous lesions arising from cartilage, bone, fibrous tissue, or vascular elements. These lesions include entities such as osteochondroma, enchondroma, chondroblastoma, osteoid osteoma, and giant cell tumor of bone, each with distinct imaging and clinical characteristics. Many benign lesions are discovered incidentally and may remain asymptomatic, with diagnosis often based on imaging features in conjunction with individual age, lesion location, and growth behavior (Expert Panel on Musculoskeletal Imaging, 2024; NCCN, 2026).

Evidence Discussion

Plain radiography is the primary imaging modality for benign bone tumors because many lesions have characteristic appearances that allow accurate diagnosis without additional imaging. Evidence demonstrates that radiographs provide sufficient

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information to classify lesions based on margins, matrix, and periosteal reaction, enabling differentiation between benign and aggressive processes in most cases (Expert Panel on Musculoskeletal Imaging, 2024). Utilizing radiographs as the initial and often sole imaging modality reduces unnecessary radiation exposure, cost, and downstream testing associated with more advanced imaging.

Advanced imaging with MRI or CT is supported when radiographic findings are indeterminate or when there are features concerning for malignancy. MRI, in particular, offers superior soft tissue characterization and can help define lesion extent, evaluate marrow involvement, and guide biopsy planning when needed. CT provides complementary information regarding cortical integrity and matrix mineralization. Restricting advanced imaging to these scenarios improves diagnostic accuracy while minimizing unnecessary imaging in clearly benign lesions (Expert Panel on Musculoskeletal Imaging, 2024; NCCN, 2026).

Selective use of advanced imaging also helps mitigate potential harms associated with overimaging, including false-positive findings, incidentalomas, and unnecessary invasive procedures. In lesions without aggressive radiographic features, further imaging has not been shown to improve outcomes, supporting a conservative approach. Additionally, routine surveillance with advanced imaging for benign lesions with low risk of malignant transformation has not demonstrated clinical benefit, reinforcing the importance of risk-adapted imaging strategies (NCCN, 2026).

The use of PET/CT is not supported in the evaluation of benign bone tumors due to the lack of evidence demonstrating diagnostic or clinical benefit in this setting. PET/CT may produce nonspecific findings and has limited ability to distinguish benign from malignant lesions without histologic confirmation. Avoiding PET/CT in this context reduces unnecessary radiation exposure and prevents misinterpretation that could lead to inappropriate interventions (Expert Panel on Musculoskeletal Imaging, 2024; NCCN, 2026).

Health Equity Considerations

Although benign bone tumors (BBTs) are nonmalignant and often asymptomatic, inequities in access to health care, diagnostic imaging, and specialty evaluation can significantly influence detection, monitoring, and outcomes. Many BBTs are diagnosed incidentally through imaging performed for unrelated symptoms, making access to timely radiography, CT, or MRI a critical determinant of diagnosis. In medically underserved populations, limited access to primary care and diagnostic imaging may result in underdiagnosis, delayed identification, or presentation only after complications such as pain, pathologic fracture, or local tissue compression occur (Martin et al., 2025). Evidence from a large retrospective study in the Rio Grande Valley, a region characterized by high poverty rates, limited insurance coverage, and reduced health-care access, demonstrates substantially lower observed incidence of

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BBTs compared with national estimates, likely reflecting barriers to care rather than true differences in disease prevalence (Martin et al., 2025). These findings underscore how socioeconomic disadvantage and health-system access shape detection of benign musculoskeletal conditions.

Disparities may also manifest across age, sex, and cultural contexts, affecting patterns of care utilization. In predominantly Hispanic underserved communities, sociocultural factors such as medical mistrust and gender norms may further discourage early evaluation, particularly among men, contributing to delayed or missed diagnoses (Martin et al., 2025). Because some benign bone tumors can exhibit aggressive local behavior or require longitudinal imaging surveillance to assess growth or rare malignant transformation, inconsistent access to follow-up imaging can lead to avoidable morbidity (Martin et al., 2025). Standardized, evidence-based oncology imaging guidelines play an important role in promoting equity by supporting appropriate initial evaluation, differentiation from malignant lesions, and consistent surveillance strategies regardless of care setting. When applied alongside efforts to improve access to imaging services and specialty referral in underserved populations, guideline-concordant imaging can help reduce disparities and ensure safe, effective management of benign bone tumors.

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Benign Bone Tumors - Initial Work-Up/ Staging (ONC-12.10)

ON.SS.0012.10.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Giant Cell Tumor of Bone (GCTB)	ANY or ALL of the following: • MRI without contrast or without and with contrast of involved area • CT (contrast as requested) of involved area • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast • Bone scan (CPT® 78306)
Enchondroma	• MRI without contrast or without and with contrast of primary site

Background and Supporting Information

Benign bone tumors encompass a spectrum of nonmalignant osseous lesions, including giant cell tumor of bone (GCTB) and enchondroma, which may have variable clinical behavior ranging from indolent to locally aggressive. While many benign lesions are identified on radiographs, certain tumor types require further characterization due to overlapping imaging features with malignant lesions or potential for local recurrence, malignant transformation, or metastatic spread in rare cases (NCCN, 2026).

Giant cell tumor of bone is typically a locally aggressive neoplasm that most commonly arises in the epiphyses of long bones and may demonstrate destructive growth patterns. Although classified as benign, GCTB has the capacity for pulmonary metastases and, rarely, malignant transformation. Enchondromas are common benign cartilaginous tumors that may appear indeterminate on radiographs and can mimic low-grade chondrosarcoma, necessitating further imaging evaluation to confirm diagnosis and guide management (NCCN, 2026).

Evidence Discussion

MRI and CT of the involved area are supported for the initial work-up of giant cell tumor of bone due to their complementary roles in local staging. MRI provides high-resolution

soft tissue contrast, allowing for accurate delineation of tumor extent, identification of marrow involvement, and detection of features suggestive of malignant transformation. CT offers improved visualization of cortical bone destruction and complex osseous anatomy, particularly in areas such as the spine or pelvis. The combined use of these modalities enhances diagnostic confidence and informs surgical and therapeutic planning (NCCN, 2026).

Systemic staging with CT of the chest is supported in GCTB due to its known, albeit uncommon, potential for pulmonary metastases. CT is more sensitive than chest radiography for detecting small pulmonary nodules and therefore improves detection of clinically significant metastatic disease. Similarly, whole-body bone scan is considered medically necessary for identifying multifocal osseous involvement or distant skeletal lesions. The inclusion of these modalities balances early detection of metastatic disease with the risks of radiation exposure, which is justified given the biologic behavior of GCTB (NCCN, 2026).

Imaging of the abdomen and pelvis is not routinely supported in the absence of relevant symptoms or clinical suspicion, as this pattern of metastatic spread is uncommon in GCTB. Limiting imaging to sites with established metastatic risk reduces unnecessary radiation exposure, cost, and incidental findings that may lead to further unnecessary evaluations. This risk-adapted approach aligns imaging with tumor biology and expected dissemination patterns (NCCN, 2026).

For enchondroma, MRI is supported as the primary advanced imaging modality when radiographic findings are indeterminate. MRI allows for detailed evaluation of internal tumor characteristics and helps differentiate benign enchondroma from low-grade chondrosarcoma or other malignant entities. Restricting advanced imaging to scenarios in which radiographs are inconclusive improves diagnostic accuracy while avoiding overutilization of imaging in lesions with classic benign features (NCCN, 2026).

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Benign Bone Tumors - Restaging/ Recurrence (ONC-12.11)

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v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Giant Cell Tumor of Bone (GCTB)	ANY or ALL of the following, after completion of radiotherapy or every 2 cycles of chemotherapy: • MRI without contrast or without and with contrast of involved area • CT (contrast as requested) of involved area • Bone scan (CPT® 78306)
Enchondroma	• Plain films of primary site

Background and Supporting Information

Benign bone tumors include a wide spectrum of nonmalignant osseous lesions with variable behavior, ranging from indolent, asymptomatic entities to locally aggressive tumors such as giant cell tumor of bone (GCTB). Although these tumors lack metastatic potential in most cases, certain subtypes, particularly GCTB, may recur locally, demonstrate aggressive growth, or rarely metastasize, most commonly to the lungs. Appropriate imaging during restaging is therefore important to assess treatment response and detect recurrence (NCCN, 2026).

GCTB typically arises in the epiphysis of long bones and can demonstrate destructive growth with a risk of recurrence after treatment. Management may include surgery, radiotherapy, or systemic therapy, with imaging used to evaluate both local disease control and potential spread. Enchondromas, by contrast, are common benign cartilage tumors that are typically indolent, with recurrence or progression evaluated primarily through imaging of the primary site (NCCN, 2026).

Evidence Discussion

For giant cell tumor of bone (GCTB), repeat cross-sectional imaging with MRI or CT is supported for restaging following treatment because of its role in assessing local tumor response and detecting recurrence. MRI provides detailed assessment of marrow and soft tissue involvement, while CT is useful for evaluating cortical bone and complex

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anatomy. When systemic therapy is administered, imaging every two treatment cycles allows for timely evaluation of treatment response and facilitates early modification of therapy if progression is identified. Following radiotherapy, imaging at treatment completion establishes a baseline for future surveillance (NCCN, 2026).

The addition of bone scan in GCTB is supported to evaluate for multifocal disease or metastatic spread, particularly given the tumor's potential for pulmonary and skeletal involvement. While this modality increases sensitivity for detecting distant osseous lesions, its use is typically limited to clinically appropriate scenarios to avoid unnecessary radiation exposure and false-positive findings. This targeted approach aligns with the biologic behavior of GCTB and optimizes staging accuracy without overutilization (NCCN, 2026).

For enchondroma, evidence supports the use of plain radiography as the primary modality for restaging and recurrence assessment after initial characterization. Once diagnosis is established with advanced imaging, surveillance with plain films is generally sufficient to confirm lesion stability or detect interval change. Advanced imaging in this setting has low diagnostic yield unless there are new or indeterminate findings on radiographs, or evolving clinical symptoms suggest possible malignant transformation or progression (NCCN, 2026).

Overall, the evidence supports a risk-adapted imaging strategy that differentiates between tumor types with varying biologic behavior. Use of advanced imaging for locally aggressive tumors such as GCTB enables early detection of recurrence and assessment of treatment response, while reliance on plain radiography for indolent lesions such as enchondroma minimizes unnecessary imaging, radiation exposure, and downstream interventions. This approach balances diagnostic accuracy with the potential harms of overimaging, including cost, incidental findings, and unnecessary procedures (NCCN, 2026).

Oncology Imaging Guidelines

Benign Bone Tumors – Surveillance/ Follow-up (ONC-12.12)

ON.SS.0012.12.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Giant Cell Tumor of Bone (GCTB)	ANY or ALL of the following every 6-12 months for 4 years, then annually thereafter: • Plain x-ray of primary site ◦ MRI without and with contrast for new findings on plain x-ray, or new/worsening clinical symptoms • Chest x-ray ◦ CT Chest with (CPT® 71260) or without (CPT® 71250) contrast for new findings on chest x-ray, or new/worsening signs/ symptoms
Enchondroma	Plain films of primary site

Background and Supporting Information

Benign bone tumors represent a heterogeneous group of nonmalignant osseous lesions with variable biologic behavior, ranging from indolent, asymptomatic processes to locally aggressive tumors such as giant cell tumor of bone (GCTB). While most benign tumors remain stable over time, certain subtypes may recur locally after treatment or, in rare cases, demonstrate metastatic potential, particularly in the lungs in GCTB. Surveillance strategies are therefore tailored to tumor biology and risk of recurrence (NCCN, 2026).

GCTB is characterized by locally aggressive growth and a recognized risk of recurrence following surgical or nonsurgical therapy. Recurrence most commonly occurs at the primary site, although pulmonary metastases may develop in a small subset of patients. Enchondromas, in contrast, are typically indolent and asymptomatic lesions that are often managed conservatively, with imaging focused on confirming stability rather than detecting metastasis (NCCN, 2026).

Evidence Discussion

Surveillance strategies for giant cell tumor of bone (GCTB) prioritize plain radiography for both the primary site and the chest, supported by evidence demonstrating that

routine advanced imaging has limited benefit in asymptomatic individuals. While GCTB has potential for local recurrence and pulmonary metastases, studies have not demonstrated a clear advantage of routine advanced imaging over plain film surveillance in detecting clinically meaningful recurrence. This supports the use of periodic radiographs as the primary modality, reserving MRI or CT for cases with abnormal findings or new or worsening symptoms (NCCN, 2026).

MRI of the primary site is supported when radiographic findings are indeterminate or when clinical symptoms suggest recurrence. MRI provides superior soft tissue contrast and allows differentiation between post-treatment changes and recurrent tumor, thereby improving diagnostic accuracy when concern arises. However, its routine use in asymptomatic surveillance is not supported due to lack of demonstrated benefit and the potential for increased cost and incidental findings (NCCN, 2026).

Chest surveillance with radiography is appropriate for detecting pulmonary metastases in GCTB, with CT reserved for abnormal chest radiograph findings or new respiratory symptoms. This tiered approach balances the increased sensitivity of CT for detecting small pulmonary nodules with the need to minimize cumulative radiation exposure. Limiting CT use to clinically indicated scenarios reduces unnecessary imaging and downstream interventions while maintaining appropriate detection of clinically relevant metastatic disease (NCCN, 2026).

For enchondroma, evidence supports the use of plain radiographs alone for surveillance following initial characterization. Once stability is established with advanced imaging, further surveillance with radiographs is generally sufficient to monitor for interval change. Additional advanced imaging has low diagnostic yield in the absence of concerning radiographic findings or clinical symptoms, and its routine use may lead to unnecessary costs, radiation exposure, and potential overdiagnosis (NCCN, 2026). Overall, the evidence supports a conservative, risk-adapted surveillance approach that aligns imaging intensity with tumor biology while minimizing harms associated with overimaging.

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Pancreatic Cancer (ONC-13)

Guideline Page

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Pancreatic Cancer – General Considerations (ONC-13.0)

ON.PC.0013.0.A
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Criteria

- This guideline refers only to adenocarcinoma of the exocrine pancreas, which accounts for over 90% of pancreatic malignancies. This guideline may also be used for cancer of the Ampulla of Vater.
- Neuroendocrine and carcinoid tumors of the pancreas are not included in this guideline, see: **Neuroendocrine Cancers and Adrenal Tumors (ONC-15)**.

Background and Supporting Information

Management of pancreatic adenocarcinoma requires accurate staging and determination of resectability, which are critical to guiding treatment decisions. NCCN emphasizes that evaluation should occur in a multidisciplinary setting at high-volume centers, incorporating expertise from radiology, surgery, medical oncology, and other specialties to optimize outcomes (NCCN, 2026).

Health Equity Considerations

Pancreatic cancer is characterized by high morbidity and mortality, with most individuals presenting at an advanced stage and limited opportunities for curative treatment. Substantial disparities have been consistently documented across the continuum of care, particularly by race, socioeconomic status, insurance coverage, and geography. Black individuals in the United States experience higher incidence and mortality rates than White individuals, driven in part by higher rates of advanced-stage disease at diagnosis and persistent inequities across multiple regions and age groups (Tavakkoli et al., 2020). Racial and ethnic minority populations, including Hispanic individuals, are also more likely to present at younger ages or with multiple risk factors, while facing barriers to timely diagnosis, referral, and treatment (Halder et al., 2023; Noel & Fiscella, 2019). These inequities are compounded by the absence of effective population-based screening modalities, making access to early diagnostic imaging and specialist evaluation especially critical for improving outcomes.

Socioeconomic factors further influence access to guideline-concordant imaging, staging, and treatment. Individuals who are uninsured, publicly insured, or of lower socioeconomic status are less likely to undergo surgical resection, receive multimodality therapy, or be treated at high-volume multidisciplinary centers, all of which are associated with improved outcomes in pancreatic cancer (Noel & Fiscella, 2019;

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Patel et al., 2025). Disparities also emerge earlier in the care pathway, including reduced participation of Black and other underrepresented individuals in surveillance programs for pancreatic cysts and early detection initiatives, despite similar stated willingness to engage in imaging surveillance or surgery when offered (Yip-Schneider et al., 2024). Evidence-based oncology imaging guidelines can help mitigate these inequities by promoting consistent diagnostic evaluation, staging, and follow-up across diverse practice settings. When paired with efforts to improve access to high-quality imaging, specialty referral, and coordinated multidisciplinary care, standardized imaging pathways support equitable delivery of care and may help reduce outcome disparities in pancreatic cancer.

Oncology Imaging Guidelines

Pancreatic Cancer – Screening Studies for Pancreatic Cancer (ONC-13.1)

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Criteria

- Detailed history of any known inherited syndrome in the individual and detailed family history in first- and second-degree relatives, including the age and lineage, is essential to guide screening recommendations. See table below for age- and risk-specific screening recommendations.
- New onset of diabetes in individuals older than 50 has been recognized as a potential indicator of the development of pancreatic cancer. Approximately 1% of individuals in this category are diagnosed with cancer within 3 years. A prediction model has been established which identifies those individuals at greatest risk for pancreatic malignancy. The scoring system, known as ENDPAC (Enriching New-Onset Diabetes for Pancreatic Cancer) is based on 3 discriminatory factors, including change in blood glucose, change in weight, and age of onset at the time of the new diagnosis of diabetes. A score of greater than 3 imparts an elevated risk of pancreatic cancer (3.6%), and these individuals should be screened. Screening is not considered medically necessary at this time for scores of 0-2.

Indications	Medically Necessary Imaging Study
Individuals who meet **BOTH** of the following criteria: • One or more first- or second-degree relative affected with pancreatic cancer **AND** • Known mutation carrier of ONE of the following genes: ◦ Lynch Syndrome (MLH1, MSH2, or MSH6 gene mutations) ◦ BRCA1 ◦ PALB2 mutation ◦ EPCAM ◦ TP53	• MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) starting at age 50 or 10 years earlier than the youngest family member affected with exocrine pancreatic cancer, repeat annually

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Indications	Medically Necessary Imaging Study
Individuals with family history of pancreatic cancer but no known genetic mutation: • Individuals with 2 relatives with pancreatic cancer where one is a first-degree relative • Individuals with 3 or more relatives with pancreatic cancer	• MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) starting at age 45 or 10 years earlier than the youngest family member affected with exocrine pancreatic cancer, repeat annually
Pancreatic Cancer Kindred (individuals who have at least one first-degree relative with pancreatic cancer who in turn also has a first-degree relative with pancreatic cancer) and NO known genetic germline mutations	• MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) starting at age 50 or 10 years earlier than the youngest family member affected with exocrine pancreatic cancer, repeat annually
Hereditary Pancreatitis (PRSS1, CPA1, and CTRC gene mutations)	• MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) beginning at age 40 or 20 years after the first pancreatitis attack, repeat annually
Peutz-Jeghers Syndrome (LKB1/STK11 gene mutation)	• MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) starting at age 30 or 10 years earlier than the youngest family member affected with exocrine pancreatic cancer, repeat annually ◦ Family history is not required to begin imaging at age 30

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Indications	Medically Necessary Imaging Study
CDKN2A mutation (also known as p16, p16INK4a, and MTS1, FAMM-Familial Atypical Multiple Melanoma and Mole Syndrome)	• MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) beginning at age 40 or 10 years earlier than the youngest family member affected with exocrine pancreatic cancer, repeat annually ◦ Family history is not required to begin imaging at age 40
• BRCA2 • ATM (Ataxia-Telangiectasia)	• MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) starting at age 50 or 10 years earlier than the youngest family member affected with exocrine pancreatic cancer, repeat annually ◦ Family history is not required to begin imaging at age 50
Screening MRI for pancreatic cancer reveals cystic lesion of the pancreas	• Repeat MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) in 6 months
Screening MRI for pancreatic cancer reveals indeterminate solid lesion	• CT Abdomen with contrast – pancreatic protocol (CPT® 74160) • Repeat MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) in 3 months after the CT scan
Screening MRI for pancreatic cancer reveals pancreatic stricture and/or dilation 6mm or greater without a mass	• CT Abdomen with contrast – pancreatic protocol (CPT® 74160) • Repeat MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) in 3 months after the CT scan

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Indications	Medically Necessary Imaging Study
New onset diabetes in adults with ENDPAC score of 3 or higher	• CT Abdomen without and with contrast (CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) at baseline; if negative, repeat once after 6 months

Background and Supporting Information

ENDPAC scoring:

Blood Glucose (BG) Categories		Change BG Category Score (NOD-1y)(A)
BG Range (mg/dl)	Score	Score Range
BG Category at -1 years		1-4
<100	1	
100-109	2	
110-125	3	
BG Category at Glycemically-Defined New-Onset Diabetes		
126-160	4	
>160	5	
Change Weight Categories		Change Weight Score (B)
Change Weight (kg)	Score	Score Range
≤-6.0	+6	-6 to +6
-5.9 to -4.0	+4	
-3.9 to -2.0	+2	
-1.9 to +1.9	0	
+2.0 to +3.9	-2	
+4.0 to +5.9	-4	
≥+6.0	-6	
Age (years) at glycemically-defined new-onset diabetes		Age Score (C)

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Blood Glucose (BG) Categories		Change BG Category Score (NOD-1y)(A)
Age Range	Score	Score Range
≤59	-1	-1 to +1
60 to 69	0	
≥70	+1	
Total Score		A + B + C

Pancreatic cancer screening is focused on identifying early-stage pancreatic adenocarcinoma or high-grade precursor lesions in individuals at elevated risk, as outcomes remain poor when disease is diagnosed at an advanced stage. Risk stratification is primarily based on family history and pathogenic germline mutations in cancer susceptibility genes. High-risk groups include individuals with multiple affected first- or second-degree relatives and those with inherited syndromes such as BRCA-associated hereditary cancer syndromes, Lynch syndrome, Peutz-Jeghers syndrome, CDKN2A-associated familial atypical multiple mole melanoma, and hereditary pancreatitis (Goggins et al., 2020; NCCN, 2026).

Screening eligibility and timing are guided by estimated lifetime risk and underlying genetic predisposition. Consensus recommendations support initiation of screening at age 50 or 10 years earlier than the youngest affected relative, with earlier initiation for higher-risk syndromes such as Peutz-Jeghers or CDKN2A mutation carriers. These recommendations are designed to align screening with the natural history of disease development and earlier onset observed in hereditary populations (Goggins et al., 2020; NCCN, 2026).

In addition to hereditary and familial risk factors, new-onset diabetes in older adults has emerged as a clinically relevant marker associated with pancreatic cancer development. Predictive models such as ENDPAC incorporate age, weight change, and glycemic trends to identify individuals at increased short-term risk, supporting targeted imaging in this population (Goggins et al., 2020).

Evidence Discussion

Screening for pancreatic cancer is supported in select high-risk populations based on evidence demonstrating a substantially elevated lifetime risk and the potential for improved outcomes through early detection. The CAPS Consortium and NCCN recommend surveillance in individuals with familial clustering or pathogenic germline mutations, as these groups exceed the risk threshold at which screening may provide clinical benefit (Goggins et al., 2020; NCCN, 2026). Observational studies of surveillance programs have shown a shift toward detection of earlier-stage disease and

Oncology Imaging Guidelines

high-grade precursor lesions, which are associated with improved survival compared to typical presentation at advanced stages (Goggins et al., 2020; Abe et al., 2019; de Jong et al., 2023).

In contrast, screening is not supported for average-risk individuals due to the lack of demonstrated mortality benefit and the potential harms associated with overdiagnosis and unnecessary interventions. The USPSTF has concluded that population-based screening carries moderate risk, including false-positive findings, invasive follow-up procedures, and psychological burden (USPSTF, 2019; Goggins et al., 2020). Additional studies have highlighted the low yield of screening in individuals without defined risk factors, reinforcing the need for strict adherence to risk-based eligibility criteria (Khayat et al., 2024; Hajibandeh et al., 2023).

MRI with or without MRCP is the preferred screening modality due to its high sensitivity for detecting early pancreatic lesions and its ability to evaluate pancreatic ductal anatomy without ionizing radiation. Comparative studies demonstrate that MRI and EUS are superior to CT for detection of small cystic or solid lesions, which are key targets for early diagnosis (Goggins et al., 2020; Kato et al., 2020). CT is appropriately reserved for further evaluation of indeterminate findings, improving diagnostic specificity while minimizing unnecessary radiation exposure (Goggins et al., 2020).

Short-interval follow-up imaging for indeterminate findings and targeted screening in individuals with new-onset diabetes and elevated ENDPAC scores are supported by evidence demonstrating the potential for rapid disease progression and increased short-term risk in specific populations. Data suggest that pancreatic cancer can progress from early to advanced stages within a relatively short timeframe, supporting repeat imaging at 3–6 months for suspicious findings (Goggins et al., 2020; de Jong et al., 2023). Additionally, risk prediction models incorporating metabolic changes improve identification of individuals most likely to benefit from imaging, thereby optimizing resource utilization and minimizing harms associated with unnecessary screening (Khayat et al., 2024; NCCN, 2026).

Oncology Imaging Guidelines

Pancreatic Cancer – Suspected/ Diagnosis (ONC-13.2)

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Criteria

Indication	Medically Necessary Imaging Study
For any suspected symptoms of pancreatic cancer only (e.g., epigastric pain, weight loss, pain radiating to back, etc.)	• Ultrasound (CPT® 76700 or CPT® 76705) • Also see: **Right Upper Quadrant and Epigastric Pain (AB-2.3)**
Symptoms suspicious for pancreatic cancer AND any one of the following: • Abnormal labs (e.g., elevated CA 19-9, ALKP, bilirubin, or GGTP) • Abnormal physical exam findings (e.g., abdominal mass) • Abnormal or non-diagnostic ultrasound/ERCP	Any ONE of the following: • CT Pancreatic Protocol (CT Abdomen with contrast with dual phase imaging, CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377)
Preoperative studies for potentially resectable pancreatic tumors without confirmed histologic diagnosis	• See: **Pancreatic Cancer – Initial Work-up/ Staging (ONC-13.3)**

Background and Supporting Information

Pancreatic adenocarcinoma is an aggressive malignancy with a high mortality rate and is frequently diagnosed at an advanced stage due to the absence of early symptoms and the difficulty of visualizing the pancreas on routine imaging. Common presenting symptoms include epigastric pain radiating to the back, weight loss, jaundice, and fatigue, although these findings are often nonspecific and overlap with benign conditions (NCI, 2023).

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Evidence Discussion

For individuals with suspected pancreatic cancer based on symptoms alone, ultrasound is supported as an initial imaging modality due to its wide availability, absence of ionizing radiation, and ability to assess hepatobiliary causes of symptoms. However, evidence demonstrates that ultrasound has limited sensitivity for pancreatic lesions, particularly small tumors or lesions obscured by bowel gas, necessitating further evaluation when clinical suspicion persists (Pu et al., 2021; NCI, 2023). This supports its role as an initial screening tool rather than a definitive diagnostic modality.

When symptoms are accompanied by abnormal laboratory findings, physical exam abnormalities, or inconclusive initial imaging, cross-sectional imaging with CT pancreatic protocol or MRI is supported. CT demonstrates high diagnostic performance, with reported sensitivity and specificity for pancreatic cancer detection approaching 90% and 87%, respectively, allowing accurate identification of tumor location, size, vascular involvement, and metastatic disease (Pu et al., 2021). CT also offers advantages of rapid acquisition, broad availability, and lower cost, but exposes patients to ionizing radiation.

MRI provides comparable diagnostic accuracy, with sensitivity and specificity reported at approximately 89% and 90%, respectively, and offers improved characterization of soft tissue structures and pancreatic ductal anatomy (Pu et al., 2021). This makes MRI particularly useful in cases where CT findings are indeterminate or when ductal abnormalities are suspected. The lack of radiation exposure is an important benefit; however, MRI is more costly, less accessible, and may be limited by patient tolerance and contraindications. The similar diagnostic performance of CT and MRI supports flexibility in modality selection based on clinical context and patient-specific considerations.

Advanced imaging modalities such as PET/CT may provide additional functional and metabolic information but are not recommended as first-line diagnostic tools due to limitations in distinguishing malignancy from inflammatory conditions such as pancreatitis and reduced sensitivity for small lesions (Pu et al., 2021). False-positive findings from inflammatory processes and false-negative results in small tumors highlight the importance of reserving PET/CT for problem-solving scenarios. Overall, the evidence supports a stepwise imaging approach that begins with ultrasound and progresses to high-resolution cross-sectional imaging, balancing diagnostic accuracy with risks such as radiation exposure, cost, and potential for unnecessary downstream testing.

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Pancreatic Cancer – Initial Work-up/ Staging (ONC-13.3)

ON.PC.0013.3.A
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Criteria

Indication	Medically Necessary Imaging Study
All individuals with pancreatic cancer	• CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with (CPT® 74177) or CT Abdomen and Pelvis without and with contrast (CPT® 74178)
For any of the following in individuals with pancreatic cancer: • Preoperative planning • CT insufficient to determine resectability	• MRI Abdomen without and with contrast (CPT® 74183) OR MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) AND/ OR • CTA Abdomen (CPT® 74175) and Pelvis (CPT® 72191) OR MRA Abdomen (CPT® 71485) and Pelvis (CPT® 72198)
Evaluation of indeterminate liver lesions in individuals with pancreatic cancer	• MRI Abdomen without and with contrast (CPT® 74183) OR • MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377)
No evidence of metastatic disease on CT or MRI AND any of the following in individuals with pancreatic cancer: • Equivocal or indeterminate conventional imaging findings • Markedly elevated CA 19-9 • Large primary tumor(s) • Enlarged regional lymph nodes • Planned neoadjuvant therapy	• PET/CT (CPT® 78815)

Background and Supporting Information

Pancreatic adenocarcinoma is a highly aggressive malignancy characterized by early local invasion and micrometastatic spread, resulting in poor overall survival. At the time of diagnosis, only a minority of patients have disease confined to the pancreas and amenable to surgical resection, which remains the only potentially curative treatment (Sohal et al., 2020; Brennan et al., 2007). Accurate initial staging is therefore essential to determine resectability and guide appropriate management strategies.

Evidence Discussion

Contrast-enhanced CT of the chest, abdomen, and pelvis is the primary modality for initial staging due to its ability to comprehensively evaluate disease extent, including local tumor invasion, vascular involvement, and distant metastases. ASCO guidelines recommend multiphase CT as part of the initial assessment because the benefits of accurate staging and treatment planning outweigh the risks, particularly given the aggressive nature of pancreatic adenocarcinoma and its high likelihood of metastatic disease at presentation (Sohal et al., 2020).

The determination of resectability is a critical component of staging, as surgical resection offers the only potential for long-term survival. CT imaging provides essential information regarding tumor relationship to adjacent vasculature, which directly influences surgical decision-making. Evidence demonstrates that multidetector CT and CT angiography can accurately assess vascular invasion and anatomic variants, improving preoperative planning and reducing intraoperative complications (Brennan et al., 2007). However, CT may have limitations in characterizing small or indeterminate lesions, particularly in the liver.

MRI is supported as an adjunct modality when CT is insufficient for evaluation of resectability or characterization of indeterminate findings. MRI offers superior soft tissue contrast and enhanced sensitivity for detection and characterization of hepatic lesions, which may alter staging and management. The use of MRI in this context improves diagnostic accuracy but is balanced against limitations including higher cost, longer acquisition times, and reduced accessibility (Sohal et al., 2020).

PET/CT is a selective adjunct in individuals without apparent metastatic disease on conventional imaging but who demonstrate high-risk features such as large primary tumors, elevated tumor markers, or equivocal findings. Evidence indicates that PET/CT can identify occult metastatic disease and may impact management decisions by preventing unnecessary surgical intervention. However, PET/CT is not recommended as a primary staging modality due to limitations in spatial resolution, reduced sensitivity for small lesions, and potential false-positive findings in inflammatory conditions (Sohal et al., 2020). Overall, a tiered imaging strategy, using CT as the primary modality, MRI for problem-solving, and PET/CT selectively, optimizes staging accuracy while minimizing harms such as unnecessary radiation exposure, cost, and downstream procedures.

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Pancreatic Cancer – Restaging/ Recurrence (ONC-13.4)

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Criteria

Indication	Medically Necessary Imaging Study
For ANY of the following in individuals with pancreatic cancer: • After neoadjuvant therapy • Post-operative baseline • Suspected recurrence	• CT Chest with contrast (CPT® 71260) • Abdominal imaging with one of the following, using same modality as used at initial evaluation: ◦ CT Abdomen and Pelvis with (CPT® 74177) ◦ CT Abdomen and Pelvis without and with contrast (CPT® 74178) ◦ MRI Abdomen without and with contrast (CPT® 74183) ◦ MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377) • CT with contrast of other involved or symptomatic areas
Unresectable disease or metastatic disease on chemotherapy in individuals with pancreatic cancer	Every 2 cycles of treatment (commonly every 6 to 8 weeks): • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with (CPT® 74177) or CT Abdomen and Pelvis without and with contrast (CPT® 74178) • CT with contrast of other involved or symptomatic areas
Unexplained elevated liver enzymes or inconclusive recent CT abnormality in individuals with pancreatic cancer	• MRI Abdomen without and with contrast (CPT® 74183) or MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377)
If complete surgical resection was initial therapy in individuals with pancreatic cancer	• See: **Pancreatic Cancer – Surveillance/Follow-up for surveillance imaging (ONC-13.5)**

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Indication	Medically Necessary Imaging Study
Inconclusive findings on conventional imaging in individuals with pancreatic cancer	• PET/CT (CPT® 78815)

Evidence Discussion

Cross-sectional imaging with contrast-enhanced CT of the chest, abdomen, and pelvis is supported for restaging following neoadjuvant therapy, establishment of a postoperative baseline, and evaluation of suspected recurrence due to the high likelihood of residual, recurrent, or metastatic disease. Pancreatic adenocarcinoma frequently demonstrates early progression and dissemination, and imaging is essential to reassess resectability and detect interval metastatic disease before proceeding with further therapy. This approach helps avoid nonbeneficial surgical intervention and guides appropriate treatment planning, particularly given that a minority of patients are candidates for curative resection (NCCN, 2026; Brennan et al., 2007).

For individuals with unresectable or metastatic disease receiving systemic therapy, interval imaging every two cycles (approximately every 6–8 weeks) is supported to evaluate treatment response and detect progression. Evidence indicates that pancreatic cancer has a high rate of progression during therapy, and serial imaging enables timely modification of treatment regimens when progression or lack of response is identified. This approach balances the benefits of early detection of progression with the risks of repeated radiation exposure and cost, which are justified in the context of aggressive disease biology and the need for dynamic treatment decision-making (NCCN, 2026).

MRI is supported as a complementary modality, particularly in the setting of indeterminate findings on CT or unexplained liver enzyme abnormalities. MRI offers improved soft tissue contrast and increased sensitivity for detection and characterization of liver lesions compared with CT, which is especially important given the liver is a common site of metastasis in pancreatic cancer. The selective use of MRI enhances diagnostic accuracy while minimizing unnecessary imaging utilization and associated resource burden (NCCN, 2026).

PET/CT is supported in cases with inconclusive conventional imaging or discordant clinical findings to evaluate for occult metastatic disease. Evidence demonstrates that PET/CT can improve detection of extra-pancreatic disease and may alter management decisions; however, it is not recommended as a primary modality due to limitations including false-positive findings from inflammatory processes and reduced sensitivity for small lesions (Pu et al., 2021). Restricting PET/CT to problem-solving scenarios balances its clinical benefit with potential harms such as additional radiation exposure,

increased cost, and risk of overdiagnosis, supporting a tiered imaging strategy aligned with disease biology (NCCN, 2026; Pu et al., 2021).

Oncology Imaging Guidelines

Pancreatic Cancer – Surveillance/Follow-up (ONC-13.5)

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Criteria

Indication	Medically Necessary Imaging Study
All individuals with pancreatic cancer (other than resected ampullary cancer)	Every 3 months for 2 years, then annually: • CT Chest with contrast (CPT® 71260) And ANY ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Individuals with resected ampullary cancer	Every 3 months for 2 years, then every 6 months for up to 5 years: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • CT Abdomen and Pelvis with contrast (CPT® 74177) or MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Measurable metastatic disease on maintenance therapy or being monitored off therapy in individuals with pancreatic cancer	Every 3 months for up to 5 years after completion of definitive treatment, then annually: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) or MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)

Background and Supporting Information

Pancreatic adenocarcinoma is characterized by an aggressive clinical course, with high rates of recurrence even after curative-intent therapy. Both local recurrence and distant metastases are common following surgery or systemic therapy, reflecting the presence of micrometastatic disease at diagnosis in many individuals (NCCN, 2026).

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Evidence Discussion

Evidence supporting surveillance imaging in pancreatic cancer is limited, and recommendations are largely based on expert consensus rather than high-level data. NCCN noted that while recurrence is common, available observational data, including population-based analyses, have not demonstrated a clear survival benefit from routine surveillance imaging or earlier detection of recurrence. This supports a balanced approach to follow-up that incorporates imaging alongside clinical evaluation rather than reliance on imaging alone (NCCN, 2026).

Despite limited survival benefit, routine imaging with contrast-enhanced CT of the chest, abdomen, and pelvis is supported at defined intervals because it provides objective assessment of disease status and may inform management decisions, including eligibility for additional systemic therapy or clinical trials. Cross-sectional imaging is particularly important in the early post-treatment period when recurrence risk is highest, and establishing a consistent imaging modality allows for reliable longitudinal comparison (NCCN, 2026).

For individuals with measurable metastatic disease undergoing maintenance therapy or observation, serial imaging every 3 months is supported to monitor disease stability or progression. Pancreatic cancer is characterized by rapid progression, and timely detection of interval progression allows for modification of treatment strategies. However, ASCO and other expert groups emphasize that imaging should be integrated with clinical assessment, as frequent imaging may not always translate into meaningful changes in outcomes and may expose patients to cumulative radiation and increased healthcare costs (NCCN, 2026).

Surveillance recommendations for resected ampullary cancer similarly rely on consensus, with NCCN advising periodic imaging combined with clinical evaluation and tumor markers. Imaging intervals are more frequent in the first two years due to higher recurrence risk, followed by less frequent imaging thereafter. This approach aims to balance early detection of recurrence with the potential harms of overimaging, including incidental findings, patient anxiety, and unnecessary interventions (NCCN, 2026).

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Upper GI Cancers (ONC-14)

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Hepatocellular Carcinoma (HCC) – General Considerations (ONC-14.1)

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Criteria

- A biopsy is not always required for the diagnosis of Hepatocellular carcinoma (HCC). A dedicated triple-phase CT or MRI is considered medically necessary. MRI with contrast is the test of choice for the evaluation of liver masses. It offers soft tissue contrast resolution superior to CT as well as the possibility of using two different contrast agents, one of which if more blood flow based and the other which also is blood flow based and demonstrates hepatobiliary function (Eovist). Classical imaging findings include:
  - arterial phase hyper-enhancement
  - venous phase washout appearance
  - capsule appearance
  - threshold growth
- For individuals who are high-risk for developing HCC (cirrhosis, chronic Hepatitis B or current or prior HCC), if the liver lesion is greater than 1cm with 2 classic enhancements on triple-phase CT or MRI, the diagnosis is confirmatory and biopsy is not needed.
- For lesions less than 1cm or with less than 2 classical enhancements or for any liver lesions in individuals who are not high-risk, a biopsy is needed for histological confirmation. PET/CT scan is considered not medically necessary for the diagnosis or staging of HCC.

Background and Supporting Information

Hepatocellular carcinoma (HCC) is the most common primary malignancy of the liver, accounting for the majority of liver cancers and typically arising in the setting of chronic liver disease or cirrhosis. Major etiologies include chronic hepatitis B and C infection, alcohol-related liver disease, and metabolic dysfunction-associated steatotic liver disease. Disease prognosis is influenced by both tumor burden and underlying liver function, often assessed using staging systems such as the Barcelona Clinic Liver Cancer (BCLC) classification (Mazza et al., 2024; NCCN, 2026).

Evidence Discussion

Noninvasive imaging-based diagnosis of hepatocellular carcinoma is supported by evidence demonstrating that multiphase CT and MRI can reliably identify the

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characteristic vascular profile of HCC, including arterial phase hyperenhancement and portal venous washout. In individuals with cirrhosis or chronic hepatitis B, these imaging findings have high specificity, allowing for diagnosis without biopsy. This approach reduces patient risk by avoiding invasive procedures and associated complications such as bleeding and tumor seeding, while also enabling more rapid initiation of treatment (NCCN, 2026).

The restriction of imaging-based diagnosis to high-risk populations is supported by differences in disease prevalence and diagnostic accuracy. In high-risk individuals, lesions meeting established imaging criteria have a very high likelihood of representing HCC, whereas in low-risk individuals or when imaging features are incomplete, the probability of alternative diagnoses increases. In these cases, biopsy is necessary to establish histologic confirmation and exclude other malignancies such as cholangiocarcinoma or mixed tumors, supporting a risk-adapted diagnostic strategy (NCCN, 2026).

MRI is a preferred modality in many cases due to its superior soft tissue contrast and ability to assess both vascular characteristics and hepatobiliary function using specialized contrast agents. This improves detection and characterization of smaller or indeterminate lesions compared with CT. However, CT remains an appropriate alternative due to its accessibility, speed, and cost advantages, reflecting a balance between diagnostic performance and resource utilization in clinical practice (NCCN, 2026).

Serum biomarkers such as alpha-fetoprotein (AFP) and advanced imaging modalities such as PET/CT have limited roles in primary diagnosis. AFP lacks sufficient sensitivity and specificity, with many early-stage tumors demonstrating normal values and elevations occurring in nonmalignant conditions. PET/CT has limited sensitivity for HCC, particularly in well-differentiated or small lesions, and is therefore not recommended for routine diagnosis or staging. Restricting the use of these modalities minimizes unnecessary testing, radiation exposure, and diagnostic uncertainty while emphasizing imaging modalities with established diagnostic accuracy (Mazza et al., 2024; NCCN, 2026).

Health Equity Considerations

Hepatocellular carcinoma (HCC) disproportionately affects individuals from historically marginalized populations, with persistent inequities observed across incidence, stage at diagnosis, treatment receipt, and survival. In the United States, American Indian/Alaska Native, Hispanic, Black, and Asian/Pacific Islander populations experience higher HCC incidence compared with non-Hispanic White individuals, reflecting unequal distributions of chronic hepatitis B and C, metabolic dysfunction–associated steatotic liver disease, alcohol-related liver disease, and structural determinants of health (Flores et al., 2021; Guo et al., 2021; Jing et al., 2026; Rezaee-Zavareh et al., 2024).

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Socioeconomic disadvantage, including lower income, limited educational attainment, and underinsurance, is independently associated with later-stage presentation and worse survival across racial and ethnic groups, with Black individuals consistently experiencing the highest likelihood of advanced disease and lowest survival even after adjustment for stage and treatment (Flores et al., 2021; Ong et al., 2025; Zheng et al., 2026). Geographic factors, such as residence in rural or nonmetropolitan areas and greater distance from specialty centers, further exacerbate disparities through reduced access to surveillance, multidisciplinary care, and curative therapies (Nephew et al., 2026; Zheng et al., 2026).

Inequities in HCC outcomes are strongly influenced by barriers to timely surveillance, diagnostic imaging, and treatment navigation. Racial and ethnic minorities and those with low socioeconomic status are less likely to receive guideline-concordant HCC surveillance and more likely to report challenges related to transportation, health literacy, medical mistrust, time burden, and financial strain, all of which contribute to delayed diagnosis and lower receipt of curative therapy (Schoenberger et al., 2024; Patel et al., 2025; Ong et al., 2025). Intersectional analyses demonstrate that compounded social risk, such as being uninsured, publicly insured, socially isolated, or living in highly deprived or geographically distant communities, is associated with markedly lower rates of early-stage diagnosis and curative treatment and substantially higher mortality (Nephew et al., 2026). Health equity–informed imaging and care pathways that account for these structural and social barriers, promote timely access to diagnostic evaluation, and support navigation to appropriate treatment are essential to reducing disparities and improving outcomes for individuals at highest risk of poor HCC prognosis (Guo et al., 2021; Zheng et al., 2026).

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Hepatocellular Carcinoma (HCC) – Suspected/Diagnosis (ONC-14.2)

ON.GI.0014.2.A

v1.0.2027

- See: **Chronic Liver Disease, Cirrhosis and Screening for HCC (AB-26.1)** in the Abdomen Imaging Guidelines.
- See: **Liver Lesion Characterization (AB-29.1)** in the Abdomen Imaging Guidelines.

Oncology Imaging Guidelines

Hepatocellular Carcinoma (HCC) – Initial Work-up/Staging (ONC-14.3)

ON.GI.0014.3.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with HCC	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) And ONE of the following: • CT Abdomen with contrast (CPT® 74160) • CT Abdomen without and with contrast (CPT® 74170) • CT Abdomen and Pelvis with contrast (CPT® 74177) or without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast • Bone scan (CPT® 78306) (for skeletal symptoms)
Inconclusive conventional imaging in individuals with HCC	• PET/CT (CPT® 78815)

Background and Supporting Information

Hepatocellular carcinoma (HCC) is a primary liver malignancy that most commonly arises in the setting of chronic liver disease and cirrhosis. Disease progression is influenced by tumor burden, vascular invasion, and hepatic functional reserve, and staging incorporates both oncologic and hepatic parameters. HCC demonstrates a propensity for intrahepatic spread and extrahepatic metastases, necessitating comprehensive imaging at diagnosis to accurately determine disease extent and guide treatment decisions (NCCN, 2026; Arora et al., 2021).

The identification of extrahepatic disease has significant implications for treatment selection, as the presence of metastatic disease generally precludes curative therapies such as resection or transplantation. Imaging strategies are therefore designed to comprehensively evaluate both hepatic and extrahepatic disease to optimize staging accuracy and inform multidisciplinary management (NCCN, 2026).

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Evidence Discussion

Initial imaging for HCC is supported by evidence demonstrating that multiphasic CT or MRI provides the most accurate assessment of intrahepatic tumor burden, including lesion number, size, vascular invasion, and overall extent of disease. These modalities are preferred over ultrasound due to their higher sensitivity and ability to characterize tumor vascularity and detect clinically significant disease, which is essential for staging and treatment planning (NCCN, 2026).

Comprehensive staging also requires evaluation for extrahepatic metastases, as HCC frequently spreads beyond the liver. Imaging of the chest is supported due to the lungs being the most common site of metastatic disease, while additional metastatic sites include bone, lymph nodes, adrenal glands, and peritoneum. Cross-sectional imaging of the abdomen and pelvis further evaluates these regions and improves detection of metastatic disease, which may significantly alter management and prognosis (Arora et al., 2021; NCCN, 2026).

Bone imaging is supported in individuals with skeletal symptoms or suspicious findings because osseous metastases occur in a significant proportion of patients with advanced disease. Targeted imaging in this setting improves detection of clinically relevant metastases and can guide symptom management and therapeutic decision-making. This selective approach balances the benefit of detecting metastatic disease with avoidance of unnecessary imaging in asymptomatic individuals (Arora et al., 2021; NCCN, 2026).

PET/CT is a problem-solving tool for inconclusive findings on conventional imaging. Evidence indicates that PET/CT may detect additional extrahepatic metastases and influence staging, but it has limited sensitivity for primary hepatic lesions and variable specificity. Therefore, it is not recommended as a primary staging modality but may provide incremental value in indeterminate cases. This selective use minimizes unnecessary radiation exposure and cost while leveraging its benefit in clarifying equivocal findings (Arora et al., 2021; NCCN, 2026).

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Hepatocellular Carcinoma (HCC) - Restaging/Recurrence (ONC-14.4)

ON.GI.0014.4.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
ONE of the following in individuals with HCC: • After initial therapy • For suspected recurrence • Individuals receiving systemic therapy (every 2 cycles)	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) And ONE of the following: • CT Abdomen with contrast (CPT® 74160) • CT Abdomen without and with contrast (CPT® 74170) • CT Abdomen and Pelvis with contrast (CPT® 74177) or CT Abdomen and Pelvis without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Inconclusive conventional imaging in individuals with HCC	• PET/CT (CPT® 78815)
Hepatocellular Carcinoma treated with local therapy (ablation, embolization)	See: **Liver Metastases (ONC-31.2)** for imaging studies prior to and post-procedure
Hepatocellular Carcinoma awaiting liver transplant	See: **Liver Transplant, Pre-Transplant (AB-42.1)** in the Abdomen Imaging Guidelines

Evidence Discussion

Cross-sectional imaging is essential for restaging and evaluation of hepatocellular carcinoma following therapy, as it provides accurate assessment of treatment response, detection of residual disease, and identification of recurrence. Multiphase CT or MRI of the abdomen and pelvis are supported because they reliably evaluate intranodular arterial vascularity, which is a critical imaging feature distinguishing viable tumor from post-treatment changes. These modalities also allow assessment of tumor burden,

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vascular invasion, and intrahepatic progression, supporting their use after initial therapy and for suspected recurrence or new liver lesions (NCCN, 2026).

Imaging of the chest is supported in conjunction with abdominal imaging because of the risk of extrahepatic disease, particularly given that HCC may present with or develop metastatic disease in sites such as the lungs, lymph nodes, and bone. Evidence demonstrates that extrahepatic metastases may be present in a significant proportion of patients at diagnosis and can also develop during treatment or surveillance. Comprehensive imaging of the chest, abdomen, and pelvis enables accurate restaging, informs prognosis, and helps guide decisions regarding continued systemic therapy or transition to alternative treatment approaches (Arora et al., 2021; NCCN, 2026).

For individuals receiving systemic therapy, interval imaging is supported to monitor treatment response and detect disease progression. HCC demonstrates variable treatment response and may develop new intrahepatic or extrahepatic lesions over time. Serial imaging allows timely identification of progression or lack of response, enabling clinicians to modify therapy accordingly. While repeated imaging carries risks such as cumulative radiation exposure and cost, these are justified by the aggressive disease course and the need for ongoing reassessment to optimize treatment outcomes (Arora et al., 2021; NCCN, 2026).

PET/CT is a problem-solving modality in cases of inconclusive findings on conventional imaging. Evidence indicates that PET/CT has limited sensitivity for detecting primary hepatic lesions but can identify additional extrahepatic metastases and provide complementary metabolic information. Its selective use in indeterminate scenarios improves diagnostic confidence while minimizing unnecessary radiation exposure, false-negative interpretation of liver disease, and undue resource utilization. This targeted approach aligns with its strengths and limitations in HCC imaging (Arora et al., 2021; NCCN, 2026).

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Hepatocellular Carcinoma (HCC) – Surveillance/Follow-up (ONC-14.5)

ON.GI.0014.5.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Hepatocellular Carcinoma: • Treated with surgical resection • Treated with embolization • Being monitored off therapy	Every 3 months for 2 years, then every 6 months until year 5: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) And ONE of the following: • CT Abdomen with contrast (CPT® 74160) • CT Abdomen without and with contrast (CPT® 74170) • CT Abdomen and Pelvis with contrast (CPT® 74177) or without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and Pelvis (CPT® 72197) without and with contrast
Hepatocellular Carcinoma treated with liver transplant	• See: **Liver Transplant, Post-transplant Imaging (AB-42.3)** in the Abdomen Imaging Guidelines

Background and Supporting Information

HCC is associated with a high risk of recurrence following both curative and non-curative therapies, with recurrence rates approaching 60–70% within five years after resection or ablation. Recurrence may occur early, often due to micrometastatic disease or aggressive tumor biology, or later due to de novo tumor development in the setting of chronic liver disease (Celotti et al., 2025).

Tumor biology plays a significant role in recurrence risk and long-term outcomes. Microvascular invasion (MVI), tumor size, differentiation, and presence of satellite nodules are strongly associated with increased recurrence risk and decreased overall survival. MVI in particular reflects aggressive disease and is a key determinant of both intrahepatic spread and distant metastasis (Celotti et al., 2025; Hwang et al., 2023). Surveillance imaging aims to detect recurrent or progressive disease early, both within the liver and at extrahepatic sites. Common metastatic sites include the lungs, bone,

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lymph nodes, and adrenal glands, and imaging must therefore include both hepatic and extrahepatic evaluation (Arora et al., 2021; NCCN, 2026).

Evidence Discussion

Surveillance imaging with multiphasic CT or MRI is supported due to its ability to detect recurrent or residual tumor based on characteristic arterial vascularity patterns. HCC recurrence is strongly associated with tumor vascularity, and cross-sectional imaging allows reliable assessment of arterial phase enhancement and washout patterns that distinguish viable tumor from post-treatment changes. This is particularly important in the early post-treatment period when recurrence risk is highest (NCCN, 2026).

Frequent surveillance imaging at defined intervals is supported by the high rate of recurrence after treatment, with studies demonstrating that recurrence occurs in the majority of patients within 5 years. Early recurrence, often related to micrometastatic disease or aggressive tumor features such as microvascular invasion, may occur within 2 years, justifying more intensive imaging during this period. Continued imaging beyond 2 years is supported by the risk of late recurrence, including de novo tumors in cirrhotic liver (Celotti et al., 2025).

Imaging of the chest in addition to the abdomen and pelvis is supported because of the risk of extrahepatic metastases. HCC spreads through hematogenous and lymphatic pathways, most commonly to the lungs and bone, and detection of these metastases significantly impacts staging, prognosis, and treatment decisions. Comprehensive imaging improves detection of clinically relevant disease beyond the liver and contributes to appropriate therapeutic planning (Arora et al., 2021).

While surveillance imaging provides important clinical information, it also carries potential harms, including radiation exposure, cost, and detection of incidental findings. However, given the aggressive nature of HCC, high recurrence rates, and the prognostic impact of early detection, the benefits of surveillance imaging outweigh these risks in appropriately selected individuals. A structured surveillance strategy using CT or MRI balances the need for early detection with minimization of unnecessary imaging while supporting timely intervention for recurrent disease (NCCN, 2026; Hwang et al., 2023).

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Gallbladder and Biliary Tumors – Initial Work-up/Staging (ONC-14.6)

ON.GI.0014.6.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with gallbladder and biliary tumors	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) And ONE of the following: • CT Abdomen with contrast (CPT® 74160) • CT Abdomen without and with contrast (CPT® 74170) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast • MRCP with 3D rendering (CPT® 74183 and CPT® 76376 or CPT® 76377)
Inconclusive liver findings on CT (if MRI not already performed) with gallbladder and biliary tumors	MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Inconclusive findings on MRI Abdomen with gallbladder and biliary tumors	• PET/CT (CPT® 78815)

Background and Supporting Information

Gallbladder and biliary tract cancers are a group of aggressive malignancies that include gallbladder carcinoma and cholangiocarcinoma. These tumors often present with nonspecific symptoms such as abdominal pain, jaundice, and weight loss, and are frequently diagnosed at advanced stages due to delayed clinical presentation and limitations of early detection (Furlan et al., 2008; Lamarca et al., 2019).

Tumor spread commonly involves direct invasion into the liver or adjacent organs, lymphatic dissemination to regional nodes, and distant metastases via hematogenous or

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peritoneal pathways. Accurate staging requires evaluation of the chest, abdomen, and pelvis to detect nodal and distant disease, which significantly impacts resectability and prognosis (Furlan et al., 2008; NCCN, 2026).

Evidence Discussion

High-quality contrast-enhanced cross-sectional imaging of the chest, abdomen, and pelvis is supported for initial work-up and staging because it provides comprehensive evaluation of tumor extent and disease spread. CT and MRI are effective for assessing tumor penetration through the gallbladder wall or bile ducts, identifying invasion of adjacent organs or major vascular structures, and detecting lymph node and distant metastases. These imaging capabilities are essential for determining stage and guiding treatment decisions, including resectability (Furlan et al., 2008; NCCN, 2026).

CT is widely used due to its ability to characterize local disease extent and evaluate metastatic spread with high accuracy, including detection of hepatic invasion, vascular involvement, and nodal disease. MRI and MRCP provide additional benefit in detailed evaluation of the biliary tree and soft tissue contrast, which can improve detection of bile duct involvement and assist with surgical planning. Together, these modalities complement each other in characterizing both local and systemic disease burden (Furlan et al., 2008).

PET/CT is a problem-solving tool in cases of inconclusive findings on CT or MRI. Evidence demonstrates that PET/CT has high sensitivity for detecting metastatic disease, including lymph node and distant metastases, and can alter management in a meaningful proportion of patients by identifying previously occult disease. However, its lower specificity due to false-positive uptake from inflammation or biliary infection limits its routine use in initial diagnosis and supports its selective application when conventional imaging is equivocal (Lamarca et al., 2019).

The benefits of comprehensive imaging include improved staging accuracy, appropriate treatment selection, and avoidance of non-beneficial surgical interventions in patients with advanced disease. Potential harms include radiation exposure, contrast-related risks, and false-positive findings, particularly with PET/CT, which may lead to additional testing. However, given the aggressive nature of gallbladder and biliary tumors and the importance of accurate staging, the benefits of cross-sectional imaging and selective PET/CT use outweigh these risks when applied in accordance with clinical indications (Furlan et al., 2008; Lamarca et al., 2019; NCCN, 2026).

Health Equity Considerations

Gallbladder and biliary tract cancers demonstrate substantial and persistent inequities across geographic regions, socioeconomic strata, and demographic groups. Global analyses consistently show that absolute incidence, mortality, and disability-adjusted life years (DALYs) have risen markedly since 1990, despite declining age-standardized

rates, reflecting the combined effects of population growth, population aging, and uneven epidemiologic progress (Bao et al., 2025; Dai et al., 2025; Xie et al., 2025). Countries within the so-called "gallbladder cancer belt," including parts of South America and Asia, continue to experience disproportionate burden related to environmental exposures, gallstone prevalence, infectious risks, and structural barriers to early detection (Bao et al., 2025; Xie et al., 2025). Although high Socio-Demographic Index (SDI) regions often report higher incidence due in part to stronger diagnostic capacity, low- and low-middle SDI regions increasingly bear rising mortality and DALY burdens, reflecting delayed diagnosis, limited access to advanced imaging, and constrained oncologic resources (Bao et al., 2025; Dai et al., 2025).

Equity gaps are further shaped by gender and health system factors. While females historically experienced higher disease burden, recent data demonstrate a reversal in incidence trends in many higher-SDI settings, with males increasingly affected, underscoring the need for sex-specific prevention and diagnostic strategies (Dai et al., 2025; Xie et al., 2025). Health workforce analyses reveal paradoxical associations in which higher densities of conventional healthcare personnel correlate with higher reported disease burden, likely reflecting improved case detection rather than worse outcomes, whereas settings with limited diagnostic infrastructure may systematically underestimate disease prevalence (Dai et al., 2025). Together, these findings highlight the importance of equitable access to high-quality diagnostic imaging and surveillance, particularly for older adults and populations in resource-limited settings, to ensure timely diagnosis, appropriate staging, and consistent application of oncology imaging guidelines across diverse populations (Bao et al., 2025; Dai et al., 2025; Xie et al., 2025).

Oncology Imaging Guidelines

Gallbladder and Biliary Tumors – Restaging/Recurrence (ONC-14.7)

ON.GI.0014.7.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
ANY of the following in individuals with gallbladder and biliary tumors: • After initial therapy • For suspected recurrence or new liver lesions • Individuals receiving systemic chemotherapy (every 2 cycles)	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) And ONE of the following: • CT Abdomen with contrast (CPT® 74160) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Inconclusive liver findings on CT (if MRI not already performed for restaging) in individuals with gallbladder and biliary tumors	• MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Inconclusive findings on MRI Abdomen in individuals with gallbladder and biliary tumors	• PET/CT (CPT® 78815)

Evidence Discussion

Contrast-enhanced cross-sectional imaging of the chest, abdomen, and pelvis with CT or MRI is supported for restaging and detection of recurrence in gallbladder and biliary tumors due to the high likelihood of disease progression and metastatic spread. Cross-sectional imaging enables evaluation of residual or recurrent tumor at the primary site, including assessment of tumor infiltration through the gallbladder wall or bile ducts, as well as identification of hepatic invasion, vascular involvement, and direct extension into adjacent structures. These imaging capabilities are essential for determining disease status following therapy and guiding further management decisions (Furlan et al., 2008; NCCN, 2026).

Imaging of the chest in conjunction with abdominal and pelvic imaging is supported because biliary tract malignancies frequently recur or progress with nodal and distant

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metastases. Patterns of spread include lymphatic dissemination to regional nodes and hematogenous or peritoneal metastases, including liver, peritoneum, and distant organs. Comprehensive imaging allows detection of these sites of disease and supports accurate reassessment of disease burden during surveillance or systemic therapy, including at defined intervals such as during chemotherapy (Furlan et al., 2008; NCCN, 2026).

MRI is a complementary modality when CT findings are inconclusive, particularly for characterization of liver lesions or biliary involvement. MRI provides improved soft tissue contrast and enhanced evaluation of the hepatobiliary system, which may better delineate recurrent tumor from post-treatment changes or indeterminate hepatic findings. This improves diagnostic confidence in distinguishing recurrence from benign or treatment-related abnormalities (Furlan et al., 2008).

PET/CT is a problem-solving tool when CT or MRI findings are inconclusive. Evidence demonstrates that PET/CT has high sensitivity for detection of recurrent disease and distant metastases and can identify occult sites of disease that may alter patient management in a clinically meaningful proportion of cases. However, its use must be balanced against limitations in specificity, as false-positive uptake may occur in inflammatory or infectious biliary conditions, including post-treatment changes or gallbladder inflammation. Therefore, PET/CT is most appropriately utilized when standard cross-sectional imaging is equivocal, where the potential benefit of clarifying disease status outweighs the risk of false-positive findings (Lamarca et al., 2019).

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Gallbladder and Biliary Tumors – Surveillance/Follow-up (ONC-14.8)

ON.GI.0014.8.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with gallbladder or biliary tumors	Every 3 months for 2 years, and then every 6 months up to year 5: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) And ONE of the following: • CT Abdomen with contrast (CPT® 74160) • CT Abdomen without and with contrast (CPT® 74170) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen and Pelvis without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Biliary carcinoma treated with liver transplant	See: **Liver Transplant, Post-transplant Imaging (AB-42.3)** in the Abdomen Imaging Guidelines

Background and Supporting Information

Gallbladder and biliary tract cancers are associated with a high risk of recurrence following initial therapy, particularly after surgical resection. Recurrence may occur locally within the hepatobiliary system or at distant sites, and is influenced by tumor stage, lymph node involvement, and margin status. The majority of recurrences occur within the first two years following treatment, reflecting the aggressive biology and propensity for early dissemination characteristic of these malignancies (NCCN, 2026).

Evidence Discussion

Evidence supporting surveillance imaging in gallbladder and biliary tumors is limited, and current recommendations are based primarily on consensus rather than prospective trials. NCCN noted that there are no definitive data establishing an optimal imaging schedule following resection. However, surveillance imaging is supported due to the

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high risk of recurrence and the potential for imaging findings to influence subsequent management decisions (NCCN, 2026).

The recommendation for imaging every 3 months during the first 2 years and then every 6 months up to 5 years aligns with known patterns of disease recurrence. Recurrence most commonly occurs within the first 2 years after treatment, supporting more intensive imaging during this period. Continued imaging beyond 2 years addresses the risk of later recurrence and allows for ongoing assessment of disease status over time (NCCN, 2026).

Cross-sectional imaging with CT or MRI is supported for surveillance because of its ability to evaluate both local and distant recurrence. Imaging of the chest allows detection of pulmonary metastases, while abdominal and pelvic imaging assesses the liver, biliary system, lymph nodes, and peritoneum. This comprehensive approach improves detection of clinically relevant recurrence that may alter treatment strategies, including systemic therapy or palliative interventions (NCCN, 2026).

While surveillance imaging provides important clinical benefits, potential harms include cumulative radiation exposure, contrast-related risks, cost, and detection of incidental findings that may lead to unnecessary additional testing. Given the lack of strong evidence for survival benefit, imaging should be individualized based on clinical context and patient factors. However, due to the aggressive nature of biliary malignancies and high recurrence rates, periodic imaging remains justified to support timely detection of recurrence and appropriate clinical decision-making (NCCN, 2026).

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Gastric Cancer – Initial Work-up/Staging (ONC-14.9)

ON.GI.0014.9.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with gastric cancer	• CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
Gastric cancer T2 or higher	In addition to the above CTs: • PET/CT (CPT® 78815)

Background and Supporting Information

Gastric cancer is a high-incidence malignancy worldwide with significant mortality, often presenting at advanced stages where lymph node and distant metastases are common. Accurate initial staging is essential to guide treatment decisions, including selection of surgical candidates and use of perioperative systemic therapy (NCCN, 2026; Dassen et al., 2009).

Evidence Discussion

Contrast-enhanced CT of the chest, abdomen, and pelvis is the primary imaging modality for initial staging because it provides comprehensive anatomic assessment of tumor extent, nodal disease, and distant metastases. NCCN recommends CT as standard in the initial work-up, reflecting its widespread availability and ability to guide treatment selection, including identification of resectable versus metastatic disease (NCCN, 2026). However, CT has limitations, including moderate sensitivity and specificity for lymph node metastases due to reliance on nodal size criteria and difficulty distinguishing malignant from inflammatory nodes (Dassen et al., 2009).

PET/CT is an adjunct modality in individuals with ≥T2 disease because it provides complementary metabolic information that may improve staging accuracy. Evidence demonstrates that FDG uptake in primary tumors and lymph nodes is associated with more advanced pathological stages (III/IV), suggesting a potential role in identifying higher-risk disease not fully characterized by CT alone (Kudou et al., 2018). This additional information may influence treatment planning, including selection for neoadjuvant therapy.

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However, PET/CT has important limitations that support its selective rather than routine use. FDG-PET alone has limited sensitivity for detecting primary gastric tumors, especially early-stage lesions and certain histologic subtypes such as diffuse or signet ring cell carcinoma (Dassen et al., 2009). It also has reduced sensitivity for small lymph node metastases due to spatial resolution constraints, although specificity is relatively high. These limitations explain why PET/CT is not an adequate standalone staging modality and must be used in conjunction with CT.

The combined use of CT and PET/CT reflects a risk-adapted imaging strategy that balances benefits and harms. The addition of PET/CT may improve detection of advanced disease and reduce understaging, but it introduces risks including false-positive findings, additional radiation exposure, and increased cost. Therefore, restricting PET/CT to patients with ≥T2 disease optimizes diagnostic yield while minimizing unnecessary imaging, aligning with evidence that PET/CT provides incremental value primarily in more advanced disease settings (NCCN, 2026; Dassen et al., 2009; Kudou et al., 2018).

Health Equity Considerations

Gastric cancer in the United States demonstrates marked and persistent inequities by race, ethnicity, nativity, geography, and socioeconomic status, despite overall declines in national incidence and mortality. Minoritized populations, including Asian, Hispanic/Latino, Black, American Indian/Alaska Native, and certain immigrant communities, experience substantially higher incidence and mortality than non-Hispanic White populations, with elevated risk observed in nearly all U.S. counties and particularly pronounced in states and regions with larger immigrant and lower-income populations (GBD US Health Disparities Collaborators, 2023; Rabkin, 2023). These disparities largely reflect structural and social determinants rather than biologic differences alone, including higher prevalence of Helicobacter pylori infection, early-life exposure in high-incidence countries, household crowding, limited access to nutritious foods, and barriers to timely specialty care and diagnostic evaluation (Gonzalez-Pons et al., 2022; Kim et al., 2026). Socioeconomic position, especially income and educational attainment, has been shown to mediate a substantial proportion of racial and ethnic differences in gastric cancer burden, underscoring the role of modifiable structural factors in shaping outcomes (Kim et al., 2026). Importantly, heterogeneity within aggregated racial and ethnic categories (e.g., among Asian or Hispanic subgroups) may obscure groups at particularly high risk, such as Korean, Japanese, Vietnamese, and Puerto Rican populations (Gonzalez-Pons et al., 2022; Hyun & Cho, 2024).

Health equity considerations are especially relevant to imaging and diagnostic pathways, as delayed presentation and late-stage diagnosis are more common among high-risk and underserved populations, contributing to poorer survival (GBD US Health Disparities Collaborators, 2023; Rabkin, 2023). Structural barriers, including lack of insurance, limited access to high-volume cancer centers, language discordance, and

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gaps in guideline-concordant evaluation, may reduce timely use of endoscopy and cross-sectional imaging for diagnosis and staging (Hyun & Cho, 2024; Kim et al., 2026). While population-based gastric cancer screening has reduced mortality in high-incidence countries, there is no standardized U.S. screening strategy for high-risk groups, raising concerns about underdiagnosis and inequitable access to early detection (Hyun & Cho, 2024; Rabkin, 2023). Equity-informed imaging practices should therefore emphasize risk-based clinical awareness, culturally and linguistically appropriate care, and timely diagnostic imaging for symptomatic patients or those with known risk factors, with the goal of reducing disparities in stage at diagnosis and outcomes across historically marginalized populations (Gonzalez-Pons et al., 2022; Kim et al., 2026).

Oncology Imaging Guidelines

Gastric Cancer – Restaging/Recurrence (ONC-14.10)

ON.GI.0014.10.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
• After completion of primary therapy (to include chemotherapy and/or chemoradiotherapy), prior to surgery in individuals with gastric cancer • After completion of chemoradiation therapy with definitive intent (i.e., no metastatic disease and no anticipated resection surgery) in individuals with gastric cancer • For suspected recurrence in individuals with gastric cancer	• CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177)
Monitoring response to chemotherapy (every 2 cycles, ~every 6-8 weeks) for: • Unresected primary disease in individuals with gastric cancer • Metastatic disease in individuals with gastric cancer	• CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Chest with contrast (CPT® 71260)
New liver lesion(s) and primary site controlled in individuals with gastric cancer	• CT Abdomen without and with contrast (CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183)
EITHER of the following in individuals with gastric cancer: • Inconclusive findings on conventional imaging • Restaging of individuals with unresectable disease who cannot undergo CT with contrast due to renal insufficiency or contrast allergy	• PET/CT (CPT® 78815)

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Evidence Discussion

Contrast-enhanced CT of the chest, abdomen, and pelvis is supported for restaging after completion of therapy, prior to surgery, and for suspected recurrence because it provides comprehensive evaluation of locoregional disease and distant metastases. NCCN recommended cross-sectional imaging in these settings to assess treatment response, detect residual or recurrent disease, and guide further management decisions, including eligibility for surgical resection or transition to systemic therapy (NCCN, 2026). CT imaging allows consistent longitudinal comparison and is widely available, though it remains limited by moderate sensitivity in detecting small volume or early recurrent disease.

Serial imaging with CT is supported for monitoring response to chemotherapy in both unresected primary and metastatic disease. NCCN indicates that CT is used for response assessment during systemic therapy because it provides objective measurement of tumor burden and can identify new or progressive disease. Timely interval imaging allows clinicians to modify treatment strategies in response to progression, balancing the benefits of early detection of non-response with the risks of cumulative radiation exposure and cost (NCCN, 2026).

Dedicated abdominal imaging with multiphasic CT or MRI is supported for evaluation of new liver lesions, particularly when the primary site is controlled. These modalities provide improved characterization of hepatic lesions and help distinguish metastatic disease from benign or treatment-related findings. This targeted approach improves diagnostic specificity and ensures appropriate staging and management in cases where liver metastasis would significantly alter prognosis and treatment decisions (NCCN, 2026).

PET/CT is an adjunct modality in cases of inconclusive findings on conventional imaging or when CT cannot be performed due to contrast allergy or renal insufficiency. NCCN notes that PET/CT can provide additional metabolic information that may help clarify indeterminate findings and detect occult metastatic disease. However, PET/CT is not routinely required for all patients due to limitations in sensitivity for small or low-metabolic lesions and potential for false-positive findings, supporting its selective use when conventional imaging is insufficient (NCCN, 2026).

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Gastric Cancer – Surveillance/Follow-up (ONC-14.11)

ON.GI.0014.11.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Stage I (treated with resection alone) gastic cancer	• No routine imaging unless clinical signs/ symptoms of recurrence
ANY of the following: • Stage I gastic cancer treated with systemic therapy • Stages II-III gastic cancer • Stage IV gastic cancer - Metastatic disease with no measurable disease post definitive treatment	Every 6 months for 2 years, and then annually for 3 more years: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) and CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ In individuals who cannot undergo CT with contrast due to renal insufficiency or contrast allergy, MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) are considered the medically necessary substitute.
Measurable metastatic disease on maintenance therapy or being monitored off therapy in individuals with gastric cancer	Every 3 months for up to 5 years after completion of active treatment: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)

Background and Supporting Information

Gastric cancer demonstrates variable risk of recurrence based on initial stage and treatment approach, with higher-stage disease associated with increased likelihood of both locoregional and distant relapse. Follow-up strategies are therefore risk-adapted, with less intensive evaluation for early-stage disease treated definitively and more structured surveillance for individuals with higher-stage or metastatic disease (NCCN, 2026).

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Surveillance intensity reflects patterns of recurrence, which are most common within the first 2–3 years after treatment and decrease thereafter. In contrast, individuals with low-risk disease treated with resection alone have a lower likelihood of recurrence, and routine imaging may not provide additional clinical benefit in the absence of symptoms (NCCN, 2026).

Evidence Discussion

Routine imaging is not supported for individuals with stage I gastric cancer treated with resection alone in the absence of symptoms, reflecting the relatively low risk of recurrence in this population. NCCN recommended that follow-up in these individuals rely primarily on clinical evaluation, with imaging reserved for cases with concerning signs or symptoms. This approach minimizes unnecessary radiation exposure, cost, and downstream testing without compromising outcomes in low-risk patients (NCCN, 2026).

For individuals with higher-risk disease, including stage I treated with systemic therapy, stages II–III disease, and stage IV disease after definitive treatment, periodic surveillance imaging with CT of the chest, abdomen, and pelvis is supported. NCCN recommends imaging every 6 months for the first 2 years, followed by annual imaging up to 3 years, aligning with the higher likelihood of recurrence during the early post-treatment period. This structured approach enables earlier detection of recurrent disease that may be amenable to additional therapy, while reducing imaging frequency as recurrence risk declines over time (NCCN, 2026).

For individuals with measurable metastatic disease on maintenance therapy or observation, more frequent imaging is supported due to the ongoing risk of disease progression. NCCN supports imaging every 3 months in this setting to monitor disease stability or progression and guide treatment modifications. This interval balances the need for timely detection of progression with the potential harms of repeated imaging, including radiation exposure and cost, which are justified by the clinical need for close monitoring in advanced disease (NCCN, 2026).

MRI is an alternative to CT in individuals who cannot receive iodinated contrast due to renal insufficiency or allergy, ensuring continuity of surveillance imaging while avoiding contrast-related risks. Overall, a risk-adapted surveillance strategy ranging from no routine imaging in low-risk individuals to structured and frequent imaging in higher-risk and metastatic disease optimizes detection of clinically meaningful recurrence while minimizing unnecessary imaging and associated harms (NCCN, 2026).

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Neuroendocrine Cancers and Adrenal Tumors (ONC-15)

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General Considerations (ONC-15.1)

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Criteria

This guideline includes low-grade or well-differentiated carcinoid and endocrine tumors of the lung, thymus, pancreas, gastrointestinal tract, or unknown primary site; including insulinoma, glucagonoma, VIPoma, gastrinoma, somatostatinoma, and others, as well as catecholamine-secreting tumors of the adrenal gland such as pheochromocytoma, paraganglioma, adrenocortical carcinoma, and others.

- For poorly-differentiated or high-grade small cell or large cell neuroendocrine tumors arising outside the lung or from an unknown primary site, see: **Extrathoracic Small Cell and Large Cell Neuroendocrine Tumors (ONC-31.8)**.
- For poorly-differentiated or high-grade neuroendocrine tumors of the lung, see: **Small Cell Lung Cancer (ONC-7)**.
- Neuroblastoma, ganglioneuroblastoma, and ganglioneuroma occurring in adults should be imaged according to **Neuroblastoma (PEDONC-6)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
- Many are associated with Multiple Endocrine Neoplasia (MEN) familial syndromes.
  – See: **Multiple Endocrine Neoplasias (MEN) (PEDONC-2.8)** in the Pediatric and Special Populations Oncology Imaging Guidelines for screening recommendations.
- Somatostatin receptor (SSR) based imaging is more sensitive and specific for evaluation of well-differentiated neuroendocrine tumors and may be performed using ^{111}In DTPA Octreotide scintigraphy or PET/CT scan with SSR radiotracers (such as ^{68}Ga–DOTATATE, ^{68}Ga-DOTATOC, or ^{64}Cu-DOTATATE). This study is not part of evaluation of poorly-differentiated or high-grade neuroendocrine tumors, which are imaged according to: **Extrathoracic Small Cell and Large Cell Neuroendocrine Tumors (ONC-31.8)**.
- If dotatate PET/CT is medically necessary but not available, octreotide scan (any one of the following planar imaging codes: CPT® 78801, 78802, 78804 **AND** any one of the following SPECT/SPECT-CT codes: CPT® 78803, 78830, 78831, 78832) may be substituted for dotatate PET.

Background and Supporting Information

Neuroendocrine neoplasms (NENs) represent a heterogeneous group of tumors arising from neuroendocrine cells throughout the body, with variability in primary site, biologic behavior, grade, differentiation, and functional status. Well-differentiated neuroendocrine tumors (NETs) are generally distinct from poorly differentiated neuroendocrine

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carcinomas (NECs) in both prognosis and imaging characteristics, necessitating separate diagnostic and management strategies (Zhang & Kunz, 2022; NCCN, 2026).

Tumor classification and staging are based on tumor differentiation, mitotic rate, and Ki-67 proliferative index, with well-differentiated tumors stratified into grades that correlate with tumor aggressiveness and prognosis. Higher grade and proliferative index are associated with more aggressive disease behavior and worse outcomes, supporting the need for appropriate imaging to guide staging and treatment planning (Zhang & Kunz, 2022).

Somatostatin receptor (SSTR) expression is a defining feature of most well-differentiated NETs, with approximately 80% demonstrating receptor expression. This biologic characteristic allows for targeted functional imaging using radiolabeled somatostatin analogs, which has become central to staging and disease assessment (Zhang & Kunz, 2022; NCCN, 2026).

Evidence Discussion

SSTR-based imaging is a highly sensitive and specific modality for evaluation of well-differentiated neuroendocrine tumors. Approximately 80% of these tumors express somatostatin receptors, enabling effective visualization with SSTR-targeted radiotracers such as Ga-DOTATATE and Cu-DOTATATE. This functional imaging provides whole-body assessment of disease burden and can detect lesions not identified on conventional imaging, improving staging accuracy and guiding treatment selection (Zhang & Kunz, 2022; NCCN, 2026).

The combination of functional imaging with anatomic imaging (CT or MRI) is supported due to their complementary roles. Anatomic imaging provides detailed visualization of tumor size, location, and structural involvement, while SSTR-based imaging identifies receptor-positive disease and occult metastases. This dual-modality approach improves diagnostic confidence and facilitates comprehensive disease characterization, which is essential for appropriate staging and management (Zhang & Kunz, 2022; NCCN, 2026).

SSTR-based imaging is not recommended for poorly differentiated or high-grade neuroendocrine tumors because these tumors often lack somatostatin receptor expression and instead demonstrate increased metabolic activity detectable on FDG-PET or other imaging modalities. This distinction supports separate imaging pathways based on tumor differentiation, ensuring that imaging strategies align with tumor biology and avoiding reduced sensitivity in high-grade disease (Zhang & Kunz, 2022).

When SSTR PET/CT is not available, octreotide scintigraphy remains an acceptable alternative, though it has lower spatial resolution and sensitivity compared with newer PET-based techniques. The use of this modality supports continued access to functional imaging while acknowledging potential limitations, including reduced lesion detectability and longer imaging time. Overall, the evidence supports a biologically driven imaging

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strategy that maximizes diagnostic yield while minimizing unnecessary or ineffective imaging in subgroups of neuroendocrine tumors (Zhang & Kunz, 2022; NCCN, 2026).

Health Equity Considerations

Population-based and national cohort studies demonstrate meaningful disparities in the incidence, presentation, and outcomes of gastrointestinal and pancreatic neuroendocrine cancers by race, ethnicity, geography, and socioeconomic status. Non-Hispanic Black individuals experience the highest overall incidence of gastroenteropancreatic neuroendocrine neoplasms, with particularly elevated rates for small intestine, colorectal, and rectal primaries, while Hispanic populations have been shown to experience higher cancer-specific mortality for small intestine neuroendocrine tumors despite adjustment for clinical and sociodemographic factors (Paciorek et al., 2025). Socioeconomic and insurance-related factors further influence outcomes, as higher household income and private insurance or Medicare coverage are consistently associated with improved survival, whereas Medicaid coverage does not confer a similar survival benefit, highlighting persistent structural barriers beyond nominal access to care (Uhlig et al., 2024). These findings underscore that race and ethnicity function as proxies for broader upstream determinants of health, including neighborhood socioeconomic conditions, insurance stability, and healthcare access, rather than intrinsic biological differences alone (Paciorek et al., 2025; Uhlig et al., 2024).

Geographic disparities also affect diagnostic pathways, treatment access, and long-term outcomes, particularly for pancreatic neuroendocrine tumors. Patients residing in rural areas experience significantly worse overall survival following pancreatic neuroendocrine tumor resection compared with urban counterparts, even after adjustment for disease stage, comorbidities, income, and distance to treatment centers (Mirza et al., 2024). Limited availability of specialty care, longer travel distances, healthcare workforce shortages, and financial toxicity associated with prolonged surveillance and multimodality treatment may contribute to delayed diagnosis, treatment interruptions, and reduced survivorship in these populations (Mirza et al., 2024; Uhlig et al., 2024). Given the strong prognostic importance of tumor grade, stage, and timely detection, inequities in access to high-quality imaging, subspecialty consultation, and longitudinal follow-up may exacerbate outcome disparities (Malik et al., 2023). Imaging guideline implementation should therefore support equitable access to appropriate diagnostic and surveillance imaging across diverse populations, with particular attention to individuals from historically marginalized racial and ethnic groups, rural communities, and lower socioeconomic strata.

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Gastrointestinal/Pancreatic Neuroendocrine Cancers – Suspected/ Diagnosis (ONC-15.2)

ON.NA.0015.2.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
• Systemic symptoms strongly suggestive of functioning neuroendocrine tumor • Suspicious findings on other imaging studies • Unexplained elevation in ANY of the following: ◦ Chromogranin A ◦ 5HIAA ◦ Insulin ◦ VIP ◦ Glucagon ◦ Gastrin ◦ Substance P ◦ Serotonin ◦ Somatostatin	ANY of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) or without and with contrast (CPT® 74178) **OR** MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • CT with contrast or MRI without and with contrast of any other symptomatic body areas
• Continued suspicion for gastrointestinal/pancreatic neuroendocrine cancers with negative/inconclusive CT or MRI	ONE of the following: • PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE

Background and Supporting Information

Gastrointestinal and pancreatic neuroendocrine tumors (GEP-NETs) arise from neuroendocrine cells distributed throughout the gastrointestinal tract and pancreas and

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exhibit heterogeneous clinical behavior, including both functioning (hormone-secreting) and non-functioning tumors. Functioning tumors may present with characteristic clinical syndromes related to hormone overproduction, whereas non-functioning tumors are often asymptomatic and detected incidentally or at advanced stages (Hesami et al., 2024; Galgano et al., 2022).

GEP-NETs demonstrate variable biologic behavior and are frequently small and difficult to localize, particularly in early disease. Primary tumors may arise in the pancreas, small bowel, or other gastrointestinal sites, and detection is often complicated by small lesion size, variable enhancement patterns, and diverse anatomical locations (Hesami et al., 2024).

Evidence Discussion

Contrast-enhanced CT and MRI are the initial imaging modalities in individuals with suspected gastrointestinal or pancreatic neuroendocrine tumors due to their complementary strengths in tumor detection and characterization. CT provides rapid, high-resolution assessment and is effective for identifying primary small bowel tumors, lymphadenopathy, and metastatic disease, while MRI offers superior soft tissue contrast and is more sensitive for detecting pancreatic lesions and hepatic metastases. This combined approach improves detection across varied tumor types and anatomic locations (Hesami et al., 2024; Galgano et al., 2022).

The use of cross-sectional imaging of the chest, abdomen, pelvis, and other symptomatic areas is supported because neuroendocrine tumors commonly present with metastatic involvement at diagnosis, particularly in the liver, lymph nodes, and lungs. Comprehensive imaging allows accurate staging and localization, which are essential for management planning and may identify clinically occult disease not evident from biochemical testing alone (Hesami et al., 2024).

When CT or MRI findings are negative or inconclusive in the setting of continued clinical suspicion, somatostatin receptor (SSR)-based PET imaging is supported due to its high sensitivity and specificity for well-differentiated neuroendocrine tumors. SSR PET/CT provides whole-body functional imaging and can detect small primary tumors, lymph node metastases, bone lesions, and occult disease not visualized on anatomic imaging, improving diagnostic accuracy and staging (Galgano et al., 2022; Zhang & Kunz, 2022).

The selective use of SSR PET/CT following inconclusive conventional imaging balances benefits and harms. While SSR PET/CT offers high diagnostic yield and management impact, it has limitations including potential false-positive findings from physiologic or inflammatory uptake and reduced sensitivity for very small hepatic lesions. Additionally, cost and availability considerations support reserving this modality for cases with unresolved diagnostic uncertainty rather than routine first-line use. FDG-based PET has limited utility in this population because most well-differentiated GEP-NETs have low metabolic activity and may not demonstrate significant uptake (Galgano et al., 2022).

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Gastrointestinal/Pancreatic Neuroendocrine Cancers – Initial Work-up/Staging (ONC-15.3)

ON.NA.0015.3.A
v1.0.2027

Criteria

- For undifferentiated neuroendocrine tumors, see: **Extrathoracic Small Cell and Large Cell Neuroendocrine Tumors ONC-31.8**

Indication	Medically Necessary Imaging Study
ANY of the following: • Well-differentiated Grade 1 or 2 (low-grade) tumors of the following sites: ◦ Jejunal ◦ Ileal ◦ Colon ◦ Neuroendocrine tumors of unknown primary • Type 2 or 3 Gastric • Neuroendocrine tumors of unknown primary • Well-differentiated Grade 3 (high-grade) tumors *For poorly differentiated neuroendocrine tumors outside of the lung, see **Extrathoracic Small Cell and Large Cell Neuroendocrine Tumors (ONC-31.8)**	If not already done, ANY or ALL of the following: • PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • And ONE of the following: ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ CT Abdomen and Pelvis without and with contrast (CPT® 74178) ◦ MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast

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Indication	Medically Necessary Imaging Study
All other GI or pancreatic neuroendocrine tumors, including, but not limited to, duodenal, appendix (greater than 2cm or any tumor size with incomplete resection or positive nodes/margins), rectal (T2-T4 or positive nodes), and pancreas (nonfunctional, gastrinoma, insulinoma, glucagonoma, VIPoma)	If not already done: • CT Abdomen and Pelvis with contrast (CPT® 74177) or without and with contrast (CPT® 74178) OR MRI Abdomen (CPT® 74183) and Pelvis (CPT® 72197) without and with contrast • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250)
Locally advanced or metastatic gastrointestinal/pancreatic neuroendocrine tumors (any location or histology) not amenable to curative intent resection to assess candidacy for treatment with somatostatin analogues	If not already done, ANY or ALL of the following: • PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • And ONE of the following: ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ CT Abdomen and Pelvis without and with contrast (CPT® 74178) ◦ MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Inconclusive CT or MRI scans in individuals with gastrointestinal/ pancreatic neuroendocrine tumors	ONE of the following: • PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE

Indication	Medically Necessary Imaging Study
ANY of the following in individuals with gastrointestinal/pancreatic neuroendocrine tumors: • Markers fail to normalize after complete resection AND CT/MRI and somatostatin-receptor based study are negative • Biopsy-proven neuroendocrine tumor of unknown primary site AND CT/MRI and somatostatin-receptor based study are negative	• FDG-PET/CT (CPT® 78815)

Background and Supporting Information

Gastrointestinal and pancreatic neuroendocrine tumors are heterogeneous neoplasms arising from neuroendocrine cells of the digestive system and pancreas, with variable biologic behavior ranging from indolent well-differentiated tumors to more aggressive forms. Classification is based on tumor differentiation and proliferative index, which influences imaging strategy and prognosis. These tumors are frequently slow-growing but may present with metastatic disease at diagnosis, most commonly involving the liver and lymph nodes (Hesami et al., 2024; NCCN, 2026).

Well-differentiated neuroendocrine tumors often demonstrate somatostatin receptor expression, which provides a molecular target for functional imaging. In contrast, poorly differentiated tumors may have less receptor expression and require alternative imaging approaches. The biologic variability of these tumors necessitates a multimodality imaging strategy incorporating both anatomic and functional techniques (Galgano et al., 2022; NCCN, 2026).

Evidence Discussion

Cross-sectional imaging with contrast-enhanced CT or MRI of the chest, abdomen, and pelvis is the initial staging approach for gastrointestinal and pancreatic neuroendocrine tumors because it provides comprehensive anatomic evaluation of the primary tumor and metastatic disease. CT offers rapid, high-resolution imaging and is effective for detecting small bowel primaries and lymphadenopathy, while MRI provides superior soft tissue contrast and is more sensitive for detecting pancreatic tumors and hepatic metastases. These complementary strengths support the use of either modality based on clinical indication and tumor location (Hesami et al., 2024; Galgano et al., 2022).

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Somatostatin receptor (SSR)-based PET imaging is supported in addition to cross-sectional imaging for well-differentiated tumors, including grade 1–2 tumors of the small bowel, colon, and stomach, as well as grade 3 well-differentiated tumors and tumors of unknown primary. SSR PET/CT provides high sensitivity and specificity for detection of receptor-positive disease, allows whole-body assessment, and improves detection of small primary tumors, nodal metastases, bone lesions, and occult disease not visualized on CT or MRI. This improves staging accuracy and can significantly impact management decisions (Galgano et al., 2022; NCCN, 2026).

The use of SSR PET imaging in cases of locally advanced or metastatic disease is further supported for assessment of candidacy for somatostatin analog therapies, as these treatments require demonstration of receptor expression. SSR PET provides noninvasive evaluation of receptor status and disease distribution, which is essential for therapeutic planning, including selection for peptide receptor radionuclide therapy or somatostatin analog therapy (Galgano et al., 2022; NCCN, 2026).

When CT or MRI findings are inconclusive, SSR PET imaging is supported as a problem-solving tool due to its ability to identify otherwise occult disease and clarify indeterminate findings. However, limitations include potential false-positive uptake from physiologic or inflammatory processes and reduced sensitivity for very small hepatic lesions compared with high-quality MRI. FDG-PET/CT is reserved for select scenarios, such as tumors of unknown primary or cases with persistent abnormal tumor markers despite negative conventional and SSR imaging, as FDG uptake is generally limited in well-differentiated tumors but may identify more aggressive or poorly differentiated disease (Galgano et al., 2022; Hesami et al., 2024; NCCN, 2026).

Oncology Imaging Guidelines

Gastrointestinal/Pancreatic Neuroendocrine Cancers – Restaging/ Recurrence (ONC-15.4)

ON.NA.0015.4.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with gastrointestinal/pancreatic neuroendocrine cancers after surgical resection	• See: **Gastrointestinal/Pancreatic Neuroendocrine Cancers – Surveillance (ONC-15.5)**
Unresectable/metastatic disease on treatment with somatostatin analogues in individuals with gastrointestinal/pancreatic neuroendocrine cancers	• CT or MRI of involved body area no more frequently than every 3 months
Unresectable/metastatic disease on treatment with chemotherapy or PRRT (i.e., Lutathera) in individuals with gastrointestinal/pancreatic neuroendocrine cancers	• CT or MRI of involved body area every 2 cycles (6 to 8 weeks)

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Indication	Medically Necessary Imaging Study
Suspected recurrence in individuals with gastrointestinal/pancreatic neuroendocrine cancers	• PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE AND • CT Chest without contrast (CPT® 71250) or CT Chest with contrast (CPT® 71260) And ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen and Pelvis without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Continued suspicion for recurrence in individuals with gastrointestinal/pancreatic neuroendocrine cancers with negative or inconclusive CT or MRI, and PET not available	• Octreotide scan: ◦ Any one of the following planar imaging codes - CPT® 78801, 78802, or 78804 ◦ Any one of the following SPECT/SPECT-CT codes - CPT® 78803, 78830, 78831, 78832 - may be approved as an add-on
To assess candidacy for peptide receptor radionuclide therapy (PRRT) with Lutetium ^{177}Lu-dotatate in individuals with gastrointestinal/pancreatic neuroendocrine cancers	• PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE

Background and Supporting Information

Gastrointestinal and pancreatic neuroendocrine tumors (GEP-NETs) are a heterogeneous group of neoplasms arising from neuroendocrine cells, with variable biologic behavior and clinical course. Well-differentiated tumors often exhibit indolent growth but retain the potential for metastatic spread, most commonly to the liver, lymph

nodes, bone, and lungs. Disease recurrence and progression may occur even after initial treatment, necessitating ongoing imaging evaluation guided by tumor biology and treatment approach (Hesami et al., 2024; NCCN, 2026).

Treatment strategies for advanced GEP-NETs include somatostatin analogues, chemotherapy, and peptide receptor radionuclide therapy (PRRT). Imaging during therapy is used to assess treatment response and identify progression, with frequency and modality selection influenced by tumor grade, aggressiveness, and treatment type (Galgano et al., 2022; NCCN, 2026).

Evidence Discussion

For individuals with unresectable or metastatic gastrointestinal and pancreatic neuroendocrine tumors undergoing systemic therapy, interval cross-sectional imaging with CT or MRI is supported for monitoring disease status. NCCN indicated that imaging frequency should reflect tumor biology and treatment type, with less frequent imaging (e.g., every 3 months) appropriate for individuals receiving somatostatin analogue therapy due to typically indolent disease, and more frequent imaging (every 2 treatment cycles, approximately 6–8 weeks) appropriate during chemotherapy or PRRT where more rapid changes in tumor burden may occur. This approach balances timely detection of progression with minimization of unnecessary imaging (NCCN, 2026).

In the setting of suspected recurrence, combined anatomic and functional imaging is supported. CT or MRI provides detailed evaluation of disease distribution and structural involvement, while SSR-based PET/CT or PET/MRI offers high sensitivity for detecting recurrent or metastatic disease, including small lesions, nodal disease, bone metastases, and occult disease not visualized on conventional imaging. This combined approach improves diagnostic accuracy and informs clinical decision-making (NCCN, 2026).

SSR PET imaging is additionally supported to assess candidacy for peptide receptor radionuclide therapy (PRRT), as treatment efficacy depends on demonstration of somatostatin receptor expression. SSR PET provides noninvasive whole-body evaluation of receptor status and tumor burden, which is critical for patient selection and treatment planning. High sensitivity and specificity of SSR PET support its use in this context (NCCN, 2026).

Octreotide scintigraphy is reserved as a problem-solving modality when SSR PET is unavailable or inconclusive. Evidence demonstrates that octreotide scans are less sensitive and have lower spatial resolution compared with SSR PET-based imaging, limiting their diagnostic performance. Similarly, while FDG-PET/CT may have value in select cases, such as aggressive or dedifferentiated disease, it is not routinely required for well-differentiated tumors due to low metabolic activity and limited tracer uptake. Overall, a multimodality imaging strategy tailored to clinical context optimizes detection

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of recurrence while minimizing unnecessary imaging and associated harms (NCCN, 2026).

Oncology Imaging Guidelines

Gastrointestinal/Pancreatic Neuroendocrine Cancers – Surveillance (ONC-15.5)

ON.NA.0015.5.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
ANY of the following: • Appendix carcinoid <1cm, completely resected • Rectal carcinoid <1cm, completely resected • Gastric carcinoid treated with complete endoscopic resection	• Advanced imaging is not medically necessary for surveillance
Rectal carcinoid 1-2cm, completely resected	• MRI Pelvis without and with contrast (CPT® 72197) at 6 and 12 months post resection. No further routine surveillance.
All other GI neuroendocrine tumors (stomach, large and small intestine)	• CT Abdomen and Pelvis with contrast (CPT® 74177) or MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast once at 3 to 12 months post-operatively and every 12-24 months up to year 10
Unresected GI neuroendocrine tumors being monitored with observation alone	• CT Abdomen with contrast (CPT® 74160) once at 3 to 12 months from initial diagnosis, then every 3 months for 1 year, then every 6 months in year 2, and then annually up to year 10
Pancreatic neuroendocrine tumors	• CT Abdomen with contrast (CPT® 74160) once at 3 to 12 months post-operatively then annually up to year 10

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Indication	Medically Necessary Imaging Study
Unresected pancreatic neuroendocrine tumors being monitored with observation alone	• CT Abdomen with contrast (CPT® 74160) once at 3 to 12 months from initial diagnosis then annually up to year 10
Measurable metastatic disease on maintenance treatment or off therapy in individuals with gastrointestinal/pancreatic neuroendocrine tumors	• CT of involved body area no more frequently than every 3 months

Background and Supporting Information

Gastrointestinal neuroendocrine tumors are a heterogeneous group of neoplasms with variable biologic behavior and prognosis, influenced by tumor size, grade, and extent of invasion. Many tumors, particularly rectal and appendiceal lesions, are detected incidentally and are often small and well-differentiated at diagnosis, contributing to generally favorable outcomes in selected low-risk populations (Maione et al., 2021; Wang et al., 2022).

Risk of recurrence and metastatic progression is closely associated with tumor characteristics, including tumor size, grade, and lymphovascular invasion. Small, well-differentiated tumors (<1cm) have a very low risk of metastasis, while larger or higher-grade tumors demonstrate increasing risk of recurrence and distant spread. Prognosis varies widely across disease subtypes, with localized disease associated with more favorable outcomes compared with regional or metastatic disease (Maione et al., 2021; Wang et al., 2022).

Surveillance strategies are therefore risk-adapted, reflecting differences in recurrence risk across tumor types and clinical scenarios. Long-term follow-up may be required for many neuroendocrine tumors due to their indolent growth patterns and potential for late recurrence, particularly in patients with higher-risk disease features (Maione et al., 2021).

Evidence Discussion

Avoidance of routine surveillance imaging is supported for completely resected low-risk tumors such as appendiceal carcinoids <1cm, rectal carcinoids <1cm, and gastric carcinoids treated with complete endoscopic resection. These tumors demonstrate excellent prognosis with very low risk of recurrence or metastasis, and evidence

supports observation without imaging to minimize unnecessary radiation exposure, cost, and downstream testing (Maione et al., 2021; Wang et al., 2022; NCCN, 2026).

For intermediate-risk tumors such as rectal carcinoids measuring 1–2 cm, limited-duration surveillance with MRI pelvis is supported due to a measurable but relatively low risk of recurrence or nodal disease. Tumor size is a key determinant of metastatic risk, and short-term imaging allows detection of early recurrence while avoiding prolonged unnecessary follow-up in patients with otherwise favorable disease biology (Maione et al., 2021; NCCN, 2026).

For other gastrointestinal neuroendocrine tumors and pancreatic neuroendocrine tumors, periodic cross-sectional imaging with CT or MRI is supported due to the potential for delayed recurrence and metastatic spread. Neuroendocrine tumors often demonstrate indolent but persistent growth, and recurrence may occur years after initial treatment. Long-term imaging surveillance, extending up to 10 years, balances early detection of recurrence with the recognition that excessive imaging may increase cumulative costs and patient burden (Maione et al., 2021; Wang et al., 2022; NCCN, 2026).

More frequent imaging is supported in individuals with unresected tumors or measurable metastatic disease due to the higher risk of progression. In these populations, shorter imaging intervals allow timely detection of disease progression to guide management decisions. However, imaging frequency is limited (e.g., no more frequently than every 3 months) to balance clinical benefit with potential harms, including cumulative radiation exposure and unnecessary interventions. Overall, a risk-adapted surveillance approach aligns imaging intensity with tumor biology and clinical risk, optimizing detection of clinically meaningful recurrence while minimizing overuse (Maione et al., 2021; Wang et al., 2022; NCCN, 2026).

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Bronchopulmonary or Thymic Carcinoid – Initial Staging (ONC-15.6)

ON.NA.0015.6.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Initial diagnosis in individuals with bronchopulmonary or thymic carcinoid	If not already done: • CT Chest with contrast (CPT® 71260) • CT Abdomen with contrast (CPT® 74160) or without and with contrast (CPT® 74170) or MRI Abdomen (CPT® 74183) without and with contrast
Inconclusive CT or MRI scans in individuals with bronchopulmonary or thymic carcinoid	ONE of the following: • PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE
ANY of the following in individuals with bronchopulmonary or thymic carcinoid: • Markers fail to normalize after complete resection AND CT/MRI and somatostatin-receptor based study are negative • Biopsy-proven neuroendocrine tumor of unknown primary site AND CT/MRI and somatostatin-receptor based study are negative	• FDG-PET/CT (CPT® 78815) OR PET/MRI (CPT® 78813 and CPT® 76498)

Indication	Medically Necessary Imaging Study
Locally advanced or metastatic disease (any location or histology) not amenable to curative intent resection to assess candidacy for treatment with somatostatin analogues in individuals with bronchopulmonary or thymic carcinoid	If not already done, ANY or ALL of the following: • PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • And ONE of the following: ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ CT Abdomen and Pelvis without and with contrast (CPT® 74178) ◦ MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast

Background and Supporting Information

Bronchopulmonary and thymic carcinoid tumors are well-differentiated neuroendocrine neoplasms arising from neuroendocrine cells of the lung and thymus. These tumors are typically indolent but have variable metastatic potential depending on location, histologic subtype, and tumor burden. Bronchial carcinoids are more commonly diagnosed at earlier stages, whereas thymic carcinoids are more frequently advanced at presentation and associated with more aggressive disease behavior (Hesami et al., 2024).

Evidence Discussion

Contrast-enhanced CT of the chest and cross-sectional imaging of the abdomen with CT or MRI are supported for initial staging of bronchopulmonary and thymic carcinoid tumors due to their ability to evaluate both primary tumor extent and metastatic disease. CT is highly effective for assessment of thoracic disease and detection of pulmonary lesions and lymphadenopathy, while MRI offers superior sensitivity for detection of hepatic metastases, which are among the most common sites of spread. This combined anatomic imaging approach improves staging accuracy and supports treatment planning (Hesami et al., 2024; Galgano et al., 2022).

SSR-based PET imaging is supported when CT or MRI findings are inconclusive, as well-differentiated carcinoid tumors frequently express somatostatin receptors. SSR

PET imaging provides high sensitivity for detection of primary and metastatic disease, including small lesions not visualized on conventional imaging, and offers whole-body assessment. This contributes to more accurate staging and may influence management decisions, particularly in identifying occult disease (Galgano et al., 2022).

In cases where tumor markers fail to normalize after resection or when a neuroendocrine tumor is identified without a clear primary site and both anatomic and SSR imaging are negative, FDG-PET/CT is supported. Although well-differentiated carcinoid tumors often demonstrate limited FDG uptake, FDG-PET may identify higher-grade or dedifferentiated disease with increased metabolic activity, improving detection in more aggressive tumor subtypes (Galgano et al., 2022).

For individuals with locally advanced or metastatic disease not amenable to curative resection, combined anatomic imaging and SSR-based PET are supported to assess candidacy for somatostatin analog therapy. SSR PET provides critical information regarding receptor expression, which is required for therapy selection, while CT or MRI defines disease burden and distribution. This integrated imaging strategy optimizes treatment planning while limiting unnecessary imaging modalities (Hesami et al., 2024; Galgano et al., 2022).

Health Equity Considerations

Bronchopulmonary and thymic carcinoid tumors are rare neoplasms whose diagnosis and management are disproportionately affected by inequities in access to specialized imaging, pathology expertise, and multidisciplinary care. Delays in diagnosis are more common in resource-limited settings, where nonspecific respiratory symptoms may be misattributed to more prevalent infectious diseases, leading to prolonged symptom duration and more advanced disease at presentation (Deme et al., 2024). Reliance on advanced imaging modalities such as contrast-enhanced CT, somatostatin receptor imaging, and PET/CT is critical for accurate staging and surveillance, yet access to these technologies varies widely by geography, health system resources, and insurance status, contributing to disparities in timely diagnosis and optimal management (Lau et al., 2022; Soldath et al., 2021). Additionally, racial and socioeconomic differences in lung cancer imaging utilization may similarly affect patients with bronchopulmonary carcinoids, particularly because these tumors are often detected incidentally through imaging performed for other indications (Soldath et al., 2021).

Equity considerations are further compounded by the need for care at high-volume or specialty centers, which are more likely to offer lung-sparing surgical approaches, minimally invasive techniques, and guideline-concordant follow-up imaging associated with improved long-term outcomes (Soldath et al., 2021). Patients from underserved populations may face barriers such as travel distance, limited referral networks, and financial constraints that restrict access to these centers, potentially resulting in more invasive surgical procedures and reduced survival (Deme et al., 2024). For thymic

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carcinoids, disproportionate impacts may also be seen among patients with hereditary syndromes such as multiple endocrine neoplasia type 1, underscoring the importance of equitable access to genetic counseling, screening, and longitudinal imaging surveillance (Barone & Zhang, 2024; Lau et al., 2022). Efforts to standardize imaging pathways, expand access to advanced diagnostic modalities, and improve provider awareness in diverse clinical settings are essential to reducing inequities in outcomes for patients with bronchopulmonary or thymic carcinoid tumors.

Oncology Imaging Guidelines

Bronchopulmonary or Thymic Carcinoid – Restaging/Recurrence (ONC-15.7)

ON.NA.0015.7.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with bronchopulmonary or thymic carcinoid after surgical resection	• See: **Bronchopulmonary or Thymic Carcinoid - Surveillance (ONC-15.8)**
Unresectable/metastatic disease on treatment with somatostatin analogues in individuals with bronchopulmonary or thymic carcinoid	• CT or MRI of involved body area no more frequently than every 3 months
Unresectable/metastatic disease on treatment with chemotherapy or PRRT (i.e., Lutathera) in individuals with bronchopulmonary or thymic carcinoid	• CT or MRI of involved body area every 2 cycles (6 to 8 weeks)
Progression of symptoms or elevation of tumor markers in individuals with bronchopulmonary or thymic carcinoid	• CT Chest without (CPT® 71250) or CT Chest with contrast (CPT® 71260) And ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen and Pelvis without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and Pelvis (CPT® 72197) without and with contrast

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Indication	Medically Necessary Imaging Study
Continued suspicion for recurrence with negative or inconclusive CT or MRI in individuals with bronchopulmonary or thymic carcinoid	ONE of the following: • PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE
To assess candidacy for peptide receptor radionuclide therapy (PRRT) with Lutetium ^{177}Lu-dotatate in individuals with bronchopulmonary or thymic carcinoid	• PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE

Background and Supporting Information

Bronchopulmonary and thymic carcinoid tumors are well-differentiated neuroendocrine neoplasms with variable biologic behavior and potential for recurrence or progression over time. Although many bronchial carcinoids are diagnosed at earlier stages, both bronchopulmonary and thymic tumors can demonstrate metastatic spread, particularly to the liver, bone, and lungs. Restaging and recurrence assessment rely on imaging to evaluate changes in tumor burden and disease distribution following treatment (Hesami et al., 2024; Galgano et al., 2022).

Evidence Discussion

For individuals with unresectable or metastatic bronchopulmonary or thymic carcinoid tumors receiving treatment, serial imaging with CT or MRI is supported to monitor disease status and guide management decisions. Imaging intervals are based on treatment type and expected disease kinetics. In patients receiving somatostatin analogue therapy, longer intervals (e.g., no more frequently than every 3 months) are appropriate given the typically indolent course of well-differentiated tumors. In contrast, more frequent imaging (every 2 treatment cycles, approximately 6–8 weeks) is supported during chemotherapy due to the potential for more rapid disease progression or response (Galgano et al., 2022; Hesami et al., 2024).

In the setting of progression of symptoms or rising tumor markers, repeat cross-sectional imaging of the chest and abdomen/pelvis is supported because these

modalities provide detailed anatomic assessment of tumor burden, including detection of new or progressive metastatic disease. CT is particularly effective for evaluation of thoracic disease and lymphadenopathy, while MRI offers improved sensitivity for hepatic metastases, supporting their complementary use depending on clinical context (Hesami et al., 2024).

When conventional imaging with CT or MRI is negative or inconclusive despite continued clinical suspicion for recurrence, SSR-based PET imaging is supported. Well-differentiated carcinoid tumors frequently express somatostatin receptors, allowing SSR PET to identify occult disease not visualized on anatomic imaging. This modality provides whole-body evaluation and improves detection of small lesions, including bone and nodal metastases, thereby enhancing diagnostic accuracy and influencing management (Galgano et al., 2022).

The selective use of SSR PET after inconclusive conventional imaging balances clinical benefit with potential harms. While SSR PET offers improved sensitivity, limitations include availability, cost, and potential false-positive uptake in inflammatory or physiologic conditions. Therefore, reserving SSR PET for cases with unresolved diagnostic uncertainty aligns imaging selection with tumor biology and minimizes unnecessary imaging, while maintaining high diagnostic yield in suspected recurrence (Galgano et al., 2022; Hesami et al., 2024).

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Bronchopulmonary or Thymic Carcinoid – Surveillance (ONC-15.8)

ON.NA.0015.8.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Carcinoid tumors of lung or thymus	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) and CT Abdomen with contrast (CPT® 74160) once at 3 to 12 months post-resection and then annually up to year 10
Unresected primary tumors being monitored with observation alone in individuals with bronchopulmonary or thymic carcinoid	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) and CT Abdomen with contrast (CPT® 74160) once at 3 to 12 months from initial diagnosis then annually up to year 10
Asymptomatic lung or thymus distant metastasis on observation alone in individuals with bronchopulmonary or thymic carcinoid	Every 3 months for 1 year, and then every 6 months: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • CT Abdomen and Pelvis with contrast (CPT® 74177) or MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Measurable metastatic disease on maintenance treatment or off therapy in individuals with bronchopulmonary or thymic carcinoid	• CT Chest with contrast (CPT® 71260) • CT of involved body area no more frequently than every 3 months

Background and Supporting Information

Bronchopulmonary and thymic carcinoid tumors are well-differentiated neuroendocrine neoplasms classified as typical or atypical carcinoids based on mitotic activity and necrosis. These tumors generally have more favorable outcomes than poorly differentiated neuroendocrine carcinomas, although prognosis varies by histology and

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stage. Lung carcinoids are often diagnosed at earlier stages, while thymic carcinoids are more frequently advanced at presentation and associated with poorer outcomes (Baudin et al., 2021).

Tumor biology is characterized by relatively slow growth but a persistent risk of recurrence, including both local and distant disease. Recurrence may occur years after initial treatment, reflecting the indolent nature of many carcinoids. Common metastatic sites include liver, bone, lung, pleura, and pericardium, necessitating imaging strategies capable of evaluating both thoracic and extrathoracic disease (Baudin et al., 2021).

Risk stratification is based on WHO histologic classification and TNM staging, which are key determinants of prognosis and recurrence risk. Typical carcinoids generally have more favorable outcomes compared with atypical carcinoids, which have higher rates of nodal involvement and recurrence. Despite favorable survival in many patients, prolonged survival underscores the importance of long-term surveillance to detect recurrent or progressive disease (Baudin et al., 2021).

Evidence Discussion

The recommended use of CT chest and abdomen for surveillance of bronchopulmonary and thymic carcinoid tumors reflects the known distribution of recurrent and metastatic disease. Evidence demonstrates that these tumors most commonly recur in the thorax or metastasize to the liver, bone, and lung, supporting the inclusion of both chest and abdominal imaging in follow-up protocols to improve detection of clinically significant disease (Baudin et al., 2021; NCCN, 2026). Imaging confined to the chest alone may miss extrathoracic metastases, while broader imaging ensures comprehensive assessment aligned with disease biology.

The surveillance intervals outlined in the criteria are supported by the indolent but persistent nature of carcinoid tumors. Recurrence rates remain clinically meaningful over extended follow-up periods, with some recurrences occurring many years after resection, and guidelines emphasize lifelong surveillance given the frequency of late events (Baudin et al., 2021). This supports imaging at 3–12 months post-resection to establish a baseline and detect early recurrence, followed by long-term surveillance extending up to 10 years, balancing detection of relapse with avoidance of unnecessary imaging.

For individuals with unresected primary tumors or asymptomatic metastatic disease on observation, more frequent imaging is supported by the importance of radiologic tumor growth rate in guiding management. Evidence indicates that tumor growth kinetics and progression patterns are key determinants of treatment decisions, and that watchful follow-up is appropriate in selected asymptomatic patients with slow-growing disease (Baudin et al., 2021). Short-interval imaging every 3 to 6 months enables timely identification of progression while minimizing overtreatment in stable disease.

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In patients with measurable metastatic disease on treatment or observation, limiting imaging to no more frequently than every 3 months balances clinical benefit and potential harm. While frequent imaging allows earlier detection of progression requiring therapy modification, excessive imaging may increase cumulative radiation exposure and healthcare burden without improving outcomes in this generally indolent population. The recommended interval reflects a compromise that provides adequate disease monitoring while mitigating harms associated with over-imaging, consistent with guideline emphasis on adjusting follow-up intensity to tumor biology and disease trajectory (Baudin et al., 2021; NCCN, 2026).

Oncology Imaging Guidelines

Adrenal Tumors – Suspected/Diagnosis (ONC-15.9)

ON.NA.0015.9.A
v1.0.2027

Criteria

- See: **Adrenal Cortical Lesions (AB-16.1)** in the Abdomen Imaging Guidelines for evaluation of indeterminate adrenal masses.
- Adrenal tumors that involve the adrenal medulla or neural crest tissue outside the adrenal gland include pheochromocytoma, paraganglioma, and paraganglioneuroma.
  - These tumors are imaged according to sections **ONC-15.10 through ONC-15.12**.
  - Malignant adrenal tumors that involve the adrenal cortex are addressed in **Adrenocortical Carcinoma (ONC-15.13).**
- Adrenocortical carcinoma is imaged according to **Adrenocortical Carcinoma (ONC-15.13)**.
- If concern for genetic predisposition syndrome such as MEN, neurofibromatosis, or Von Hippel-Lindau disease, see screening recommendations in **Screening Imaging and Cancer Predisposition Syndromes (PEDONC-2)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

Background and Supporting Information

Adrenal tumors encompass a heterogeneous group of neoplasms arising from either the adrenal cortex or adrenal medulla, as well as extra-adrenal neural crest–derived tissue. Cortical lesions include benign adenomas and malignant adrenocortical carcinoma, while medullary-related tumors include pheochromocytomas and extra-adrenal paragangliomas. These entities differ significantly in biology, hormonal activity, and malignant potential, necessitating distinct diagnostic and imaging approaches (NCCN, 2026).

Evaluation of suspected adrenal tumors requires differentiation between functional and nonfunctional lesions, as well as characterization of malignancy risk. Imaging plays a central role in defining lesion morphology, while biochemical testing is essential for identifying hormonally active tumors such as pheochromocytoma. Neuroendocrine tumors involving the adrenal medulla or extra-adrenal paraganglia are associated with hereditary syndromes such as multiple endocrine neoplasia (MEN), von Hippel–Lindau disease, and other genetic conditions. Identification of these syndromes is critical, as they influence both initial diagnostic evaluation and long-term surveillance strategies. For these patients, evaluation often includes broader imaging and genetic risk assessment to detect multifocal or synchronous tumors (NCCN, 2026).

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Health Equity Considerations

Adrenal tumors exhibit important health equity challenges related to access to diagnostic imaging, specialty care, and longitudinal management. Population-level data demonstrate that adrenal tumor detection is closely linked to the availability and use of cross-sectional imaging, which varies substantially by geography and health system resources (Huang et al., 2025). Individuals living in rural or non-metropolitan areas and those with limited access to advanced imaging technologies are less likely to undergo timely diagnostic evaluation, contributing to delayed detection of hormonally active or clinically significant adrenal lesions (Ijaz et al., 2025). These disparities may be further compounded among older adults and socioeconomically disadvantaged populations, who face structural barriers such as limited transportation, specialist shortages, and fragmented referral pathways, all of which may hinder appropriate imaging follow-up and surveillance.

Socioeconomic and demographic factors also influence the observed burden and management of non-malignant adrenal tumors. Higher detection rates are reported in regions with higher Human Development Index and gross domestic product, likely reflecting both increased imaging utilization and greater prevalence of metabolic risk factors including obesity, hypertension, diabetes, and physical inactivity that are associated with adrenal tumor development (Huang et al., 2025). Conversely, lower reported incidence in low-resource settings may reflect underdiagnosis rather than true differences in disease prevalence, underscoring the role of inequitable diagnostic capacity (Huang et al., 2025). Within high-income countries, racial and ethnic minority patients have been shown to experience disparities in access to high-volume endocrine care and specialty imaging,

Oncology Imaging Guidelines

Adrenal Tumors – Initial Work-up/Staging (ONC-15.10)

ON.NA.0015.10.A
v1.0.2027

Criteria

- This guideline can be applied to **any primary site** (including beyond adrenal gland) for pheochromocytoma, paraganglioma, or paraganglioneuroma.

Indication	Medically Necessary Imaging Study
For ANY of the following: • Pheochromocytoma • Paraganglioma • Paraganglioneuroma	If not already done: • CT Chest without (CPT® 71250) or CT Chest with contrast (CPT® 71260) And ONE of the following (if not already done): • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen and Pelvis without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast • CT with contrast or MRI without and with contrast of primary site (i.e., neck) and any other symptomatic body areas
Hypercortisolemia with ANY of the following in individuals with adrenal tumors: • Tumor greater than 4cm • Inhomogeneous • Irregular margins • Local invasion • Other malignant imaging characteristics	ANY or ALL of the following: • FDG PET/CT (CPT® 78815) • CT Abdomen with contrast (CPT® 74160) or CT Abdomen without and with contrast (CPT® 74170) or MRI Abdomen without and with contrast (CPT® 74183)

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Indication	Medically Necessary Imaging Study
Continued suspicion for adrenal tumor with negative/inconclusive CT or MRI	ONE of the following: • PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE
All above studies (CT Chest AND CT OR MRI Abdomen +/- Pelvis, AND either a Dotatate PET or Octreoscan) done and negative/inconclusive in individuals with adrenal tumors	• FDG PET/CT scan (CPT® 78815)

Background and Supporting Information

Pheochromocytomas and paragangliomas (PPGLs) are neuroendocrine tumors arising from chromaffin cells of the adrenal medulla or from extra-adrenal paraganglia distributed throughout the sympathetic and parasympathetic nervous systems (Carrasquillo et al., 2021; Fishbein et al., 2021). These tumors may occur in the abdomen, pelvis, thorax, or head and neck, with approximately 95% located in the abdomen and pelvis and a smaller proportion in the chest (Carrasquillo et al., 2021).

Although many PPGLs are benign, metastatic disease develops in up to 15%–25% of patients and may present years after initial diagnosis, reflecting the need for thorough initial staging (Fishbein et al., 2021). Genetic predisposition plays a significant role in PPGL, with up to 40% of cases associated with germline mutations such as SDHx, RET, NF1, and VHL (Fishbein et al., 2021). These genetic factors influence tumor distribution, metastatic potential, and imaging phenotype, further supporting the need for comprehensive staging and tailored imaging strategies based on clinical and molecular risk factors.

Evidence Discussion

Cross-sectional imaging with CT or MRI is the cornerstone of initial work-up and staging of PPGL due to its ability to localize tumors, assess extent of disease, and

guide surgical planning. Evidence demonstrates that CT and MRI are highly effective for identifying adrenal and extra-adrenal lesions and evaluating local invasion and metastatic spread (Carrasquillo et al., 2021; Fishbein et al., 2021). The inclusion of chest imaging is supported by data showing that a subset of paragangliomas occur in the thorax and that metastatic disease may involve the lungs (Carrasquillo et al., 2021). This comprehensive approach improves staging accuracy but must be balanced against radiation exposure and contrast risks, particularly in younger patients or those requiring repeated imaging.

Functional imaging provides additional diagnostic value in cases of inconclusive or negative anatomic imaging and in detection of multifocal or metastatic disease. Traditional imaging with ^{123}I-MIBG demonstrates high sensitivity for pheochromocytoma but lower sensitivity for paraganglioma, while FDG PET is useful particularly in metastatic or SDHx-associated disease (Carrasquillo et al., 2021). More recent evidence supports the use of somatostatin receptor–based imaging, with ^{68}Ga-DOTA–conjugated PET demonstrating superior lesion detection compared with FDOPA PET, FDG PET, and MIBG scintigraphy (Han et al., 2019). A meta-analysis reported pooled detection rates of approximately 93% for ^{68}Ga-DOTA PET, significantly higher than comparator modalities, supporting its use as a problem-solving tool when conventional imaging is inconclusive (Han et al., 2019).

The use of functional imaging after negative or inconclusive CT/MRI is further supported by its ability to detect small lesions and bone metastases that may not be visualized on anatomic imaging. Studies demonstrate that PET-based imaging can identify additional lesions that alter management in a meaningful proportion of patients, improving staging accuracy and guiding therapy selection (Carrasquillo et al., 2021; Han et al., 2019). However, these benefits must be balanced against increased cost, availability limitations, and radiation exposure, supporting a stepwise approach in which functional imaging is reserved for specific indications rather than routine use.

In patients with suspected aggressive adrenal tumors or hypercortisolemia with concerning imaging characteristics, advanced imaging including FDG PET/CT is supported by evidence showing that malignant lesions tend to demonstrate increased metabolic activity and more aggressive radiographic features. Imaging findings such as tumor size, irregular margins, and local invasion are associated with higher risk of malignancy and justify more comprehensive staging (Fishbein et al., 2021). Overall, the evidence supports a tiered imaging strategy in adrenal tumors, beginning with cross-sectional imaging for localization and staging, followed by selective use of functional imaging to resolve diagnostic uncertainty and improve detection of metastatic disease while minimizing unnecessary imaging-related harms.

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Adrenal Tumors – Restaging/Recurrence (ONC-15.11)

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v1.0.2027

Criteria

- This guideline can be applied to **any primary site** (including beyond adrenal gland) for pheochromocytoma, paraganglioma, or paraganglioneuroma.

Indication	Medically Necessary Imaging Study
If surgery is primary therapy in individuals with adrenal tumors	See: **ONC-15.12** for surveillance recommendations
Recurrence, progression of symptoms, or elevation of tumor markers in individuals with adrenal tumors	• CT Chest without contrast (CPT® 71250) or CT Chest with contrast (CPT® 71260) • CT with contrast of primary site (i.e., neck) and involved areas And ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen and Pelvis without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Continued suspicion for recurrence with negative or inconclusive CT or MRI in individuals with adrenal tumors	ONE of the following: • PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}Cu-DOTATATE

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Indication	Medically Necessary Imaging Study
To assess candidacy for peptide receptor radionuclide therapy (PRRT) with Lutetium ^{177}Lu-dotatate in individuals with adrenal tumors	• PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498) with any ONE of the following SSR radiotracers: ◦ ^{68}Ga-DOTATATE ◦ ^{68}Ga-DOTATOC ◦ ^{64}CU-DOTATATE
For ANY of the following in individuals with adrenal tumors: • All above studies done and negative/ inconclusive • Hypercortisolemia with inconclusive findings on CT • Pheochromocytoma bone-dominant disease • Paraganglioma bone-dominant disease	• FDG-PET/CT scan (CPT® 78815)

Background and Supporting Information

Pheochromocytomas and paragangliomas (PPGLs) are neuroendocrine tumors with potential for recurrence or delayed metastatic spread, even many years after initial treatment (Fishbein et al., 2021). Recurrence may occur locally in the surgical bed due to incomplete resection or tumor spillage, or as distant metastatic disease involving lymph nodes, bone, liver, and lung (Fishbein et al., 2021). Because histopathology alone cannot reliably distinguish tumors that will recur or metastasize, long-term surveillance and restaging imaging are essential components of management (Fishbein et al., 2021).

Evidence Discussion

In individuals with suspected recurrence or progression of adrenal tumors, cross-sectional imaging with CT or MRI is the primary modality for restaging, as it provides accurate assessment of disease extent and distribution. Evidence demonstrates that CT and MRI are highly effective for detecting local recurrence, evaluating involvement

of adjacent structures, and identifying distant metastases, including those in the lungs, liver, and bone (Carrasquillo et al., 2021; Fishbein et al., 2021). The inclusion of chest imaging is supported by the potential for thoracic metastases and the need for comprehensive staging. This approach improves clinical decision-making but carries potential harms, including cumulative radiation exposure and contrast-related risks, particularly with repeated imaging.

When conventional imaging is negative or inconclusive but clinical suspicion persists, functional imaging provides significant incremental diagnostic value. Evidence shows that PET-based imaging modalities can detect lesions not visualized on CT or MRI, particularly in cases of multifocal or metastatic disease, thereby improving staging accuracy and influencing management (Carrasquillo et al., 2021). Among available tracers, somatostatin receptor–based PET imaging (e.g., ^{68}Ga-DOTATATE) demonstrates high lesion detection rates, with pooled sensitivity around 93% and superior performance compared with FDG PET, FDOPA PET, and MIBG scintigraphy (Han et al., 2019). These characteristics support its use as a problem-solving tool in the setting of inconclusive anatomic imaging.

Somatostatin receptor PET imaging also plays an important role in evaluating candidacy for peptide receptor radionuclide therapy (PRRT), as it identifies tumors expressing somatostatin receptors and predicts therapeutic response. Evidence indicates that high uptake on somatostatin receptor imaging correlates with suitability for targeted radionuclide therapy, making this modality essential for treatment planning in advanced disease (Carrasquillo et al., 2021; Han et al., 2019). However, the use of these studies involves higher cost and limited availability, supporting selective application based on clinical need rather than routine use.

FDG PET/CT provides additional benefit in specific clinical scenarios, including aggressive or metabolically active disease, bone-dominant metastases, or persistent suspicion after negative anatomic and somatostatin receptor imaging. Evidence demonstrates that FDG PET has variable but often high sensitivity in metastatic PPGL and can identify lesions missed by other modalities, particularly in certain genetic subtypes (Carrasquillo et al., 2021). While FDG PET may improve detection in these settings, it also introduces additional radiation exposure and cost, reinforcing its role as a secondary or complementary modality when other imaging is inconclusive.

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Adrenal Tumors – Surveillance (ONC-15.12)

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Criteria

- This guideline can be applied to **any primary site** (including beyond adrenal gland) for pheochromocytoma, paraganglioma, paraganglioneuroma, or hypercortisolemia.

Indication	Medically Necessary Imaging Study
All individuals with adrenal tumors	Once within 3-12 months post resection and then annually for 10 years: • CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250) • CT Abdomen and Pelvis with contrast (CPT® 74177) or MRI Abdomen and Pelvis without and with contrast (CPT® 74183 and 72197) • CT with contrast of primary site (i.e., neck) and other involved body areas
Measurable metastatic disease being observed off therapy or on maintenance treatment in individuals with adrenal tumors	• CT of involved body area no more frequently than every 3 months for up to 5 years after completion of definitive therapy and annually thereafter

Background and Supporting Information

Pheochromocytomas and paragangliomas (PPGLs) are neuroendocrine tumors with potential for long-term recurrence and delayed metastatic spread, including recurrence many years after definitive therapy (Fishbein et al., 2021). These tumors frequently metastasize to lymph nodes, bone, liver, and lung, and recurrence may occur locally or distantly even after complete surgical resection (Fishbein et al., 2021). The inability to reliably predict tumor behavior based on initial pathology necessitates prolonged surveillance in all patients.

Evidence Discussion

The recommended surveillance strategy using periodic CT or MRI imaging is supported by evidence demonstrating the risk of late recurrence in PPGL, including recurrence occurring many years after initial treatment. Long-term follow-up is necessary because

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metastatic disease may present after prolonged disease-free intervals, with rates of metastasis up to 15%–25% and potential latency extending beyond a decade (Fishbein et al., 2021). Imaging at 3–12 months post-resection establishes a baseline for comparison and allows early detection of recurrence, while annual surveillance for up to 10 years captures delayed relapse without excessive imaging frequency.

Cross-sectional imaging of the chest, abdomen, pelvis, and previously involved body areas is supported by the known distribution of metastatic disease. Evidence shows that PPGL commonly metastasizes to thoracic and abdominal organs, including lung and liver, justifying inclusion of chest and abdominal imaging in surveillance protocols (Carrasquillo et al., 2021; Fishbein et al., 2021). This comprehensive approach improves detection of clinically significant disease but must be balanced against cumulative radiation exposure and contrast-related risks, particularly in younger patients and those requiring prolonged monitoring.

For individuals with measurable metastatic disease under observation or on maintenance therapy, more frequent imaging is supported by the need to monitor disease progression and inform treatment decisions. Evidence indicates that metastatic PPGL may demonstrate variable growth rates, and early identification of progression can guide timely therapeutic intervention (Fishbein et al., 2021). Short-interval imaging (e.g., every 3 months) allows for assessment of tumor kinetics while minimizing unnecessary delays in management, with transition to annual imaging once disease stability is established.

Although functional imaging modalities such as somatostatin receptor PET and FDG PET demonstrate high sensitivity for lesion detection, their routine use in surveillance is not supported due to cost, availability, and radiation exposure. Evidence shows that these modalities are highly sensitive - ^{68}Ga-DOTA PET demonstrating detection rates around 93%—but are most appropriately used in cases of suspected progression or inconclusive anatomic imaging rather than routine follow-up (Han et al., 2019; Carrasquillo et al., 2021). This selective approach balances the benefit of improved detection with the potential harms of over-imaging in a population requiring long-term surveillance.

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Adrenocortical Carcinoma (ONC-15.13)

ON.NA.0015.13.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Initial staging in individuals with adrenocortical carcinoma	• FDG PET/CT (CPT® 78815) • CT Chest without (CPT® 71250) or CT Chest with contrast (CPT® 71260) And ONE of the following (if not already done): • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen and Pelvis without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Suspected recurrence in individuals with adrenocortical carcinoma	• CT Chest without (CPT® 71250) or CT Chest with contrast (CPT® 71260) And ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen and Pelvis without and with contrast (CPT® 74178) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
• Inconclusive findings on conventional imaging in individuals with adrenocortical carcinoma	• FDG PET/CT (CPT® 78815)
Surveillance after complete response to definitive treatment in individuals with adrenocortical carcinoma	Annually for 5 years: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • CT Abdomen with contrast (CPT® 74160) or MRI Abdomen (CPT® 74183) without and with contrast • CT of other involved body areas with contrast

Indication	Medically Necessary Imaging Study
Measurable metastatic disease on maintenance therapy or being monitored off therapy in individuals with adrenocortical carcinoma	Every 3 months for up to 5 years after completion of definitive therapy: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • CT Abdomen and Pelvis with contrast (CPT® 74177) or MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast • CT with contrast of other involved body areas

Background and Supporting Information

Adrenocortical carcinoma (ACC) is a rare and aggressive malignancy of the adrenal cortex, with an incidence of approximately 1–2 cases per million and variable but generally poor prognosis (Ghosh et al., 2023; Fassnacht et al., 2018). ACC may present as a functional tumor with hormone excess syndromes such as Cushing syndrome or virilization, or as a nonfunctional mass presenting with abdominal or flank pain. At diagnosis, up to 30% of individuals have metastatic disease involving the lung, liver, lymph nodes, or bone, and tumors frequently demonstrate local invasion and vascular extension (Ghosh et al., 2023; NCCN, 2026).

ACC is staged using systems such as ENSAT, incorporating tumor size, local invasion, nodal involvement, and distant metastases, which guide treatment decisions and prognosis (Fassnacht et al., 2018; NCCN, 2026). Despite treatment, ACC carries a significant risk of recurrence, including after complete surgical resection, necessitating ongoing imaging surveillance. Patterns of recurrence often mirror initial metastatic distribution, and disease course may be heterogeneous, ranging from indolent to rapidly progressive. These characteristics support risk-adapted imaging approaches throughout staging, restaging, and surveillance (Fassnacht et al., 2018; Howard et al., 2025; NCCN, 2026).

Evidence Discussion

Cross-sectional imaging with CT or MRI is the cornerstone of initial staging and restaging of ACC, given the high incidence of metastatic disease at diagnosis and the need for comprehensive anatomic assessment. Evidence demonstrates that ACC frequently involves the lung, liver, lymph nodes, and bone, supporting the inclusion of chest and abdominopelvic imaging to accurately define disease extent and guide treatment planning (Ghosh et al., 2023; NCCN, 2026). CT and MRI provide high-resolution evaluation of tumor size, local invasion, and vascular involvement, which are critical for surgical planning; however, repeated imaging introduces cumulative radiation

exposure and contrast-related risks, particularly during long-term follow-up (Fassnacht et al., 2018; Howard et al., 2025).

FDG PET/CT is supported as an adjunct to conventional imaging for initial staging and as a problem-solving tool. ACC demonstrates increased glucose metabolism, and higher FDG uptake correlates with tumor aggressiveness, tumor burden, and poorer prognosis (Ghosh et al., 2023). Functional imaging improves detection of metastatic disease and may identify lesions not well characterized by CT or MRI, thereby enhancing staging accuracy and influencing management decisions (NCCN, 2026). Evidence also shows high diagnostic performance of FDG PET/CT in detecting recurrent or metastatic disease, supporting its use when conventional imaging findings are inconclusive (Fassnacht et al., 2018; NCCN, 2026). However, PET imaging increases healthcare cost and radiation exposure, supporting its selective use rather than routine repetition.

For suspected recurrence, repeating cross-sectional imaging with CT or MRI is supported by evidence demonstrating that recurrence patterns typically mirror initial disease distribution and may involve both local and distant sites (Fassnacht et al., 2018; NCCN, 2026). Early detection of recurrence is critical given the aggressive biology of ACC and limited effectiveness of systemic therapies in advanced disease. FDG PET/CT provides additional diagnostic yield in cases of inconclusive findings, improving detection of metabolically active disease and guiding subsequent management decisions (Ghosh et al., 2023; NCCN, 2026).

Surveillance imaging strategies are supported by the risk of recurrence even after complete response to definitive therapy, with recurrence occurring in a substantial proportion of patients within the first 5 years. Annual imaging during this period balances early detection of recurrence with minimization of cumulative imaging-related harms, including radiation exposure (Fassnacht et al., 2018; NCCN, 2026). In contrast, individuals with measurable metastatic disease are at higher risk of progression, and more frequent imaging (e.g., every 3 months) allows timely assessment of treatment response and disease progression. This risk-adapted approach optimizes clinical benefit while limiting unnecessary imaging in lower-risk settings (Howard et al., 2025; NCCN, 2026).

Health Equity Considerations

Adrenocortical carcinoma (ACC) is a rare and aggressive malignancy for which timely diagnosis, high-quality imaging, and access to specialized surgical and oncologic care are critical determinants of outcome. National database analyses demonstrate significant disparities in access to potentially curative surgical resection, with lower rates of surgery observed among older individuals, males, Black individuals, and those with non-private insurance or care at community cancer centers (Hammad et al., 2017). These inequities suggest that sociodemographic and insurance-related barriers may influence referral patterns, preoperative evaluation, and access to advanced imaging

and multidisciplinary expertise required for optimal ACC management. Delays or omissions in definitive imaging and staging may disproportionately affect underserved populations, increasing the likelihood of advanced disease at presentation and limiting treatment options.

More recent analyses confirm persistent differences in treatment delivery by race and insurance status, including lower likelihood of surgery, longer time to treatment, reduced use of lymph node evaluation, and differences in postoperative length of stay among minoritiesand those without private insurance (Holoubek et al., 2022). Although overall survival did not significantly differ by race or insurance after adjustment, these disparities in care processes highlight inequitable access to high-volume endocrine surgery centers and comprehensive imaging-guided management. Imaging guidelines for ACC should therefore emphasize equitable access to high-quality cross-sectional and staging imaging, support timely referral to specialized centers, and recognize structural barriers that may limit optimal care for disadvantaged populations, with the goal of reducing disparities across the diagnostic and treatment continuum.

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Colorectal and Small Bowel Cancer (ONC-16)

Guideline Page

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Colorectal Cancer – General Considerations (ONC-16.0)

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Criteria

- Neuroendocrine tumors of the bowel are covered in: **Neuroendocrine Cancers and Adrenal Tumors (ONC-15)**.
- Appendiceal neoplasms (including pseudomyxoma peritonei) follow imaging guidelines for colorectal cancer.
- For squamous cell carcinoma of the rectum, see: **Anal Carcinoma (ONC-24)**.

Background and Supporting Information

Colorectal cancer (CRC) encompasses malignancies of the colon and rectum and is typically adenocarcinoma arising from the mucosal epithelium, often evolving from adenomatous polyps through a multistep carcinogenic process. Initial evaluation includes colonoscopy with biopsy confirmation and staging assessment to determine locoregional extent and the presence of metastatic disease, which most commonly involves the liver and lungs (NCCN, 2026).

Health Equity Considerations

Colorectal cancer (CRC) exhibits persistent and multifactorial disparities across the continuum of prevention, diagnosis, treatment, and outcomes, disproportionately affecting racial and ethnic minoritized populations, individuals with lower socioeconomic status, and those with limited access to care. Non-Hispanic Black, American Indian and Alaska Native, and Hispanic populations experience higher CRC incidence and mortality compared with non-Hispanic White populations, driven by inequities in screening uptake, delayed diagnosis, and barriers to high-quality diagnostic evaluation and treatment (Carethers & Doubeni, 2021; Hollis & Chu, 2022; Kratzer et al., 2023; Riviere et al., 2024). Geographic factors further compound these disparities, with rural residence and residence in socially disadvantaged or under-resourced urban areas associated with reduced access to timely diagnostic imaging, endoscopy, and specialty oncology care (Kratzer et al., 2023; Tsai et al., 2026). Delays in diagnosis and treatment initiation are particularly notable among younger adults with early-onset CRC, especially among male patients and racially and ethnically minoritized populations living in urban settings, underscoring structural barriers that persist even in areas with high healthcare density (Tsai et al., 2026).

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Differences in access to guideline-concordant imaging, staging, and follow-up care contribute to inequities in treatment and survival, independent of tumor biology. Although emerging evidence suggests racial and ethnic differences in molecular characteristics, such as higher prevalence of KRAS variants among non-Hispanic Black and Hispanic patients, disparities in outcomes persist even when care is standardized, pointing to the dominant influence of health system access, insurance coverage, and care coordination (Carethers & Doubeni, 2021; Rodriguez et al., 2026; Riviere et al., 2024). Populations served by safety-net systems, community health centers, and underfunded tribal health services are less likely to receive timely diagnostic imaging and complete recommended evaluation after abnormal screening tests, including cross-sectional imaging needed for accurate staging and treatment planning (Heintzman et al., 2022; Kratzer et al., 2023). Imaging guidelines for CRC should therefore prioritize equitable access to high-quality diagnostic and surveillance imaging, emphasize timely evaluation after abnormal screening results, and recognize structural and socioeconomic barriers that may impede optimal imaging utilization, with the goal of reducing downstream disparities in stage at diagnosis and outcomes.

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Colorectal Cancer – Suspected/ Diagnosis (ONC-16.1)

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- See: **GI Bleeding (AB-22)** or **CT Colonography (CTC) (AB-25.1)** in the Abdomen Imaging Guidelines for evaluation of suspected colorectal malignancies.
- See: **Abnormal Findings on Endoscopy/Colonoscopy (AB-13.3)** in the Abdomen Imaging Guidelines for evaluation of abnormal findings on endoscopy/colonoscopy.

Oncology Imaging Guidelines

Colorectal Cancer – Initial Work-up/ Staging (ONC-16.2)

ON.CC.0016.2.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Carcinoma within a polyp that is completely removed	• No advanced imaging
• Biopsy-proven invasive colon adenocarcinoma or polyp with the following high-risk features: ◦ Fragmented specimen ◦ Margin cannot be assessed ◦ Unfavorable histologic features (high grade histology (i.e., poorly differentiated), angiolymphatic invasion, depth of submucosal invasion greater than 1mm, high tumor budding, or a positive margin) • Colonoscopy findings consistent with colon cancer • Biopsy-proven low or high grade appendiceal mucinous neoplasm (LAMN or HAMN)	• CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250) AND • CT Abdomen and Pelvis with contrast (CPT® 74177)

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Indication	Medically Necessary Imaging Study
• Biopsy-proven invasive rectal adenocarcinoma or polyp with the following high-risk features: ◦ Fragmented specimen ◦ Margin cannot be assessed ◦ Unfavorable histologic features (high grade histology (i.e., poorly differentiated), angiolymphatic invasion, depth of submucosal invasion greater than 1mm, high tumor budding, or a positive margin) • Colonoscopy findings consistent with rectal cancer	• CT Chest with contrast (CPT® 71260) OR without contrast (CPT® 71250) AND ◦ Any one of the following: ▪ CT Abdomen with contrast (CPT® 74160) OR MRI Abdomen without and with contrast (CPT® 74183) AND ▪ MRI Pelvis without and with contrast (CPT® 72197) OR MRI Pelvis without contrast (CPT® 72195) (in addition to CT Pelvis if already performed)
• Further evaluation of an inconclusive liver lesion seen on CT in individuals with colorectal cancer • Potentially resectable liver metastases in individuals with colorectal cancer	• MRI Abdomen without and with contrast (CPT® 74183)
Rectal adenocarcinoma with ANY one of the following: • Rectal MRI is contraindicated • Rectal MRI is inconclusive • Superficial lesions	• Endorectal ultrasound (CPT® 76872)
ONE of the following in individuals with colorectal cancer: • Isolated metastatic lesion(s) on other imaging and individual is a candidate for aggressive surgical resection or other localized treatment to metastasis for curative intent • Inconclusive conventional imaging • Contraindication to IV contrast	• PET/CT (CPT® 78815)

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Background and Supporting Information

Colorectal cancer (CRC) includes malignancies of the colon and rectum and commonly presents as adenocarcinoma arising from the mucosal epithelium. Colon and rectal cancers are distinct entities with differences in biology, treatment, and patterns of spread (Qiu et al., 2015). At diagnosis, approximately 20% of patients have metastatic disease, most frequently involving the liver and lungs, with less common spread to bone and brain (Qiu et al., 2015). These predictable metastatic patterns inform the need for comprehensive staging imaging of the chest, abdomen, and pelvis.

Evidence Discussion

Cross-sectional imaging with CT of the chest, abdomen, and pelvis is supported as the primary modality for initial staging of colorectal cancer due to its ability to detect distant metastatic disease in the liver and lungs, which are the most common sites of spread. Evidence demonstrates that CT has a high negative predictive value (approximately 90%) for excluding distant metastases and provides a comprehensive evaluation of extrahepatic disease, supporting its role as first-line imaging in staging (Korngold et al., 2025). The benefit of CT-based staging is accurate disease classification and appropriate treatment selection, though risks include radiation exposure and contrast-related adverse effects.

For rectal cancer, MRI is supported as the preferred modality for locoregional staging due to its superior soft tissue resolution and ability to assess tumor relationship to the mesorectal fascia and surrounding pelvic structures. MRI improves assessment of tumor extent and surgical planning, particularly in determining suitability for neoadjuvant therapy and resectability (Korngold et al., 2025). This targeted use enhances staging precision but adds cost and resource utilization, supporting its use specifically for pelvic evaluation rather than systemic staging.

MRI of the abdomen is supported in selected cases for further evaluation of liver lesions or potentially resectable metastases. Evidence shows that MRI provides improved sensitivity compared with CT for detecting liver metastases, particularly in individuals with fatty liver or after chemotherapy, where CT performance may be limited (Korngold et al., 2025). This improves lesion characterization and surgical planning, though it is generally used selectively rather than as a routine replacement for CT.

FDG PET/CT is not recommended for routine initial staging but may provide value in selected cases as an adjunct to conventional imaging. Evidence demonstrates that PET/CT can identify additional metastatic disease and may change management in a subset of patients (approximately 8%–11%), although it has lower lesion-specific accuracy compared with contrast-enhanced CT or MRI and may yield false-positive results in up to 9% of cases (Korngold et al., 2025). These limitations, along with higher cost and radiation exposure, support its use as a problem-solving tool rather than standard staging imaging.

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Colorectal Cancer – Restaging/ Recurrence (ONC-16.3)

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Criteria

Indication	Medically Necessary Imaging Study
• Complete resection in individuals with colorectal cancer • Individuals with colorectal cancer receiving post-operative adjuvant chemotherapy • LAMN or HAMN post-resection	• See: **Surveillance/Follow-up (ONC-16.4)**
Recurrence suspected for colon cancer (i.e., signs or symptoms, elevated CEA)	• CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250) AND • CT Abdomen and Pelvis with contrast (CPT® 74177)
Recurrence suspected for rectal cancer (i.e., signs or symptoms, elevated CEA)	• CT Chest with contrast (CPT® 71260) OR without contrast (CPT® 71250) AND ◦ Any one of the following: ▪ CT Abdomen with contrast (CPT® 74160) OR MRI Abdomen without and with contrast (CPT® 74183) AND ▪ MRI Pelvis without and with contrast (CPT® 72197) OR MRI Pelvis without contrast (CPT® 72195) (in addition to CT Pelvis if already performed)

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Indication	Medically Necessary Imaging Study
After completion of planned neoadjuvant therapy in individuals with colorectal cancer	Prior to surgical resection in individuals with non-metastatic rectal cancer: • CT Chest with contrast (CPT® 71260) and Any ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) and MRI Pelvis without and with contrast (CPT® 72197)
Unresected primary disease or metastatic disease on chemotherapy in individuals with colorectal cancer	Every 2 cycles of chemotherapy treatment and at the completion of chemoradiotherapy: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of other involved or symptomatic areas
Individuals with colorectal cancer on adjuvant chemo/RT	Once at 3 months and then once at 4-5 months after start of treatment: • CT Chest with contrast (CPT® 71260) AND • ONE of the following: ◦ MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) OR ◦ CT Abdomen with contrast (CPT® 74160) and MRI Pelvis without and with contrast (CPT® 72197) OR ◦ CT Abdomen and Pelvis with contrast (CPT® 74177)

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Indication	Medically Necessary Imaging Study
Individuals with colorectal cancer on total neoadjuvant therapy (no resection performed or planned)	Once at 6 months and then once at 8-10 months after start of treatment: • CT Chest with contrast (CPT® 71260) AND • ONE of the following: ◦ MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) OR ◦ CT Abdomen with contrast (CPT® 74160) and MRI Pelvis without and with contrast (CPT® 72197) OR ◦ CT Abdomen and Pelvis with contrast (CPT® 74177)
• Further evaluation of an inconclusive liver lesion seen on CT in individuals with colorectal cancer • Potentially resectable liver metastases in individuals with colorectal cancer	• MRI Abdomen without and with contrast (CPT® 74183)
ONE of the following in individuals with colorectal cancer: • Postoperative elevated or rising CEA or LFTs with negative recent conventional imaging • Isolated metastatic lesion(s) on other imaging and individual is a candidate for aggressive surgical resection or other localized treatment (thermal ablation/embolization) to metastasis for curative intent • Differentiate local tumor recurrence from postoperative and/or post-radiation scarring • Liver-directed therapies (resection, ablation, embolization) are being considered and member has a contraindication to IV contrast	• PET/CT (CPT® 78815)

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Indication	Medically Necessary Imaging Study
New or worsening pelvic pain and recent CT imaging negative or inconclusive in individuals with colorectal cancer	• MRI Pelvis without and with contrast (CPT® 72197) or without contrast (CPT® 72195)

Background and Supporting Information

Colorectal cancer (CRC) includes malignancies of the colon and rectum and frequently recurs following initial therapy, particularly in patients with advanced-stage disease. Recurrence may be locoregional or metastatic, with the liver and lungs representing the most common sites of distant spread. Early identification of recurrent disease is critical, as selected individuals with limited metastatic burden may still be candidates for curative-intent treatments such as surgical resection or liver-directed therapies (NCCN, 2026).

Evidence Discussion

CT of the chest, abdomen, and pelvis is supported as the first-line imaging modality when recurrence of colorectal cancer is suspected. Evidence demonstrates that CT provides comprehensive evaluation of the most common sites of metastatic disease, including liver and lung, and allows for rapid assessment of disease burden. This facilitates timely diagnosis of recurrence and appropriate treatment planning. However, repeated CT imaging exposes patients to cumulative radiation and contrast-related risks, which must be balanced against the clinical benefit (NCCN, 2026).

Repeat imaging after completion of neoadjuvant therapy is supported to confirm the absence of disease progression prior to definitive surgical intervention. This ensures appropriate patient selection for surgery and reduces the risk of non-curative procedures in patients with interval progression. Additionally, serial CT imaging during systemic therapy is supported to assess treatment response and guide ongoing management. Imaging performed at regular intervals allows clinicians to determine whether to continue current therapy or transition to alternative treatment strategies, improving overall care (NCCN, 2026).

MRI of the abdomen is supported as an adjunct modality for further evaluation of indeterminate liver lesions or assessment of potentially resectable metastases. Evidence demonstrates that MRI provides improved sensitivity and characterization of liver metastases compared with CT, particularly in complex clinical scenarios. This enhances surgical planning and selection of candidates for curative-intent interventions, though it is generally reserved for targeted use due to resource considerations (NCCN, 2026).

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PET/CT is supported for use in specific clinical scenarios where conventional imaging is negative or inconclusive, or when there is biochemical suspicion of recurrence such as rising tumor markers. Evidence indicates that PET-based imaging can identify metabolically active disease and clarify ambiguous findings, potentially enabling curative interventions. A systematic review demonstrated high sensitivity and moderate specificity for PET-based techniques in detecting disease, reflecting strong diagnostic performance but also risk of false-positive findings (Ren et al., 2023). Limitations include cost, radiation exposure, and reduced specificity, supporting its role as a problem-solving modality rather than routine restaging imaging.

Oncology Imaging Guidelines

Colorectal Cancer – Surveillance/Follow-up (ONC-16.4)

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Criteria

Indication	Medically Necessary Imaging Study
Colon and rectal adenocarcinoma: • Stage I	• No routine advanced imaging
Colon and rectal adenocarcinoma treated with surgery: • Stage II-III	• CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) after completion of surgery and then annually for 5 years
Stage II-III rectal cancer treated with chemoradiation alone (no surgical treatment)	• CT Chest with contrast (CPT® 71260) and CT Abdomen with contrast (CPT® 74160) and MRI Pelvis (CPT® 72197) without and with contrast or without contrast (CPT® 72195) every 6 months for 3 years* after completion of chemoradiotherapy • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) every 6 months for years 4 and 5 after completion of chemoradiotherapy *CT Pelvis can replace MRI Pelvis if MRI is contraindicated
Colon and rectal adenocarcinoma: • Stage IV or distant metastatic disease (post definitive treatment on or off therapy)	• CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) every 6 months for 2 years and then annually for 3 years
Measurable metastatic disease on maintenance therapy in individuals with colorectal cancer	Every 3 months for up to 5 years after completion of active treatment: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)

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Indication	Medically Necessary Imaging Study
Rectal cancer treated with transanal excision alone	Any one of the following every 6 months for 5 years: • Endorectal ultrasound (CPT® 76872) • MRI Pelvis without and with contrast (CPT® 72197) • MRI Pelvis without contrast (CPT® 72195)
Pseudomyxoma peritonei	ONE of each of the following, every 3 months for first year, then every 6 months for 4 more years: • CT Chest with (CPT® 71260) or CT Chest without contrast (CPT® 71250) • CT Abdomen and Pelvis with contrast (CPT® 74177) or MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast or without contrast (CPT® 72195)
LAMN or HAMN	• CT Abdomen and Pelvis with contrast (CPT® 74177) or MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast or without contrast (CPT 72195) every 6 months for 2 years, then every 12 months for up to 10 years ◦ For individuals with a history of metastatic disease at any site, CT Chest with contrast (CPT® 71260) every 6 months for 2 years, then every 12 months for up to 10 years

Background and Supporting Information

Colorectal cancer (CRC) survivors represent a large and growing population, with a substantial proportion of patients at risk for recurrence following curative-intent treatment. Recurrence rates range from approximately 5% to 40%, with the highest risk occurring within the first 5 years after treatment (Hardiman et al., 2021). The most common sites of recurrence include the liver, lungs, and peritoneum, reflecting patterns of hematogenous and lymphatic spread (NCCN, 2026).

Surveillance strategies are designed to detect recurrence at an early, potentially curable stage while balancing the risks and costs of ongoing monitoring. Imaging is a core

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component of surveillance, particularly for patients with stage II–III disease or those treated with curative intent for metastatic disease, as these groups have a higher baseline risk of recurrence (Hardiman et al., 2021; NCCN, 2026).

Risk stratification based on stage, treatment history, and pathologic features guides surveillance intensity. Higher-risk patients, including those with stage II–III disease, stage IV disease treated with curative intent, or specific high-risk features, require more intensive imaging follow-up compared with patients with early-stage disease, who may not benefit from routine advanced imaging (Hardiman et al., 2021; NCCN, 2026).

Evidence Discussion

Surveillance imaging in colorectal cancer is supported by the high incidence and predictable timing of recurrence, with up to 95% of recurrences occurring within 5 years of treatment and the majority within the first 3 years (Hardiman et al., 2021). This supports the use of structured imaging protocols during this period to enable early detection of recurrence, particularly for stage II–III disease where recurrence rates are approximately 20%–30% (NCCN, 2026). Early detection may allow for curative-intent interventions such as metastasectomy, improving clinical outcomes, although repeated imaging introduces cumulative radiation exposure and cost.

The omission of routine imaging in stage I disease is supported by the low risk of recurrence and high cure rates, with survival exceeding 90% in many cases (Hardiman et al., 2021). Routine advanced imaging in this population provides limited clinical benefit and may expose patients to unnecessary harms, supporting a conservative approach. In contrast, patients with stage II–III disease benefit from regular CT imaging following surgery to establish a baseline and monitor for recurrence, with annual imaging for up to 5 years balancing detection of recurrence with minimization of imaging burden (NCCN, 2026).

In rectal cancer, additional surveillance strategies are justified in select populations due to higher risk of local recurrence. Patients treated with local excision or nonoperative management require more frequent local assessment, including endorectal ultrasound or pelvic MRI, because local recurrence rates are higher in these groups (Hardiman et al., 2021). MRI provides improved soft tissue characterization and facilitates differentiation between recurrence and post-treatment changes, supporting its use in targeted surveillance rather than routine systemic imaging alone.

For patients with stage IV disease treated with curative intent or those with measurable metastatic disease, more frequent imaging is supported to monitor for recurrence or progression. Evidence indicates that imaging at shorter intervals, such as every 3 to 6 months initially, allows timely identification of disease recurrence and facilitates treatment modification (NCCN, 2026). However, randomized trials have demonstrated that more intensive surveillance does not consistently improve overall survival compared with less intensive strategies, although it may increase detection of asymptomatic

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recurrences and opportunities for curative therapy (Hardiman et al., 2021). This underscores the importance of a risk-adapted imaging approach that balances early detection with avoidance of unnecessary imaging-related harms.

Oncology Imaging Guidelines

Small Bowel Cancer – Initial Work-up/ Staging (ONC-16.5)

ON.CC.0016.5.A
v1.0.2027

Criteria

This section provides imaging guidelines for small bowel adenocarcinoma arising from the duodenum, jejunum, and ileum.

Indication	Medically Necessary Imaging Study
Carcinoma within a polyp that is completely removed	• No advanced imaging
Invasive adenocarcinoma	• CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast ◦ MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) if CT is inconclusive or cannot be performed

Background and Supporting Information

Small bowel adenocarcinoma is a rare malignancy arising from the duodenum, jejunum, or ileum and accounts for a small proportion of gastrointestinal cancers. Despite its rarity, the disease often presents at an advanced stage, necessitating comprehensive diagnostic evaluation to determine the extent of local invasion and distant metastasis (NCCN, 2026).

The overall goal of initial staging imaging is to guide treatment planning by accurately identifying disease extent. This includes differentiating localized from metastatic disease and determining resectability, which are critical factors influencing management strategies (NCCN, 2026).

Evidence Discussion

The absence of advanced imaging for carcinoma within a polyp that has been completely removed is supported by the low likelihood of residual or metastatic disease after complete excision. Avoiding imaging in this setting reduces unnecessary radiation

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exposure, contrast-related risks, and healthcare utilization without compromising diagnostic accuracy or individual outcomes (NCCN, 2026).

For invasive adenocarcinoma, CT imaging of the chest, abdomen, and pelvis with contrast is supported as the primary modality for initial staging because it provides comprehensive evaluation of both locoregional disease and distant metastases. CT is particularly effective at identifying lesions in the liver, lungs, lymph nodes, and peritoneum, which are the most common sites of spread. This enables accurate staging and informs treatment decisions, though risks include radiation exposure and contrast-related adverse events (NCCN, 2026).

MRI of the abdomen and pelvis is supported as an adjunctive modality when CT is inconclusive or cannot be performed. Evidence indicates that MRI provides superior soft tissue characterization, particularly for indeterminate liver lesions, improving diagnostic accuracy and aiding in assessment of disease resectability. This targeted use enhances clinical decision-making while limiting unnecessary imaging (NCCN, 2026).

Overall, the recommended imaging strategy reflects a tiered approach that prioritizes CT for comprehensive staging and reserves MRI for problem-solving scenarios. This approach balances the benefits of accurate disease detection and staging with the need to minimize unnecessary imaging, radiation exposure, and resource utilization (NCCN, 2026).

Health Equity Considerations

Small bowel cancer demonstrates meaningful inequities in incidence, detection, and outcomes across racial, ethnic, socioeconomic, and geographic populations. In the United States, non-Hispanic Black individuals, particularly men, experience the highest incidence rates of small bowel cancer and steeper increases over time compared with other racial and ethnic groups, while Hispanic and Asian/Pacific Islander populations generally have lower reported incidence (Goodman et al., 2015; Mousavi et al., 2024). These disparities are likely multifactorial and reflect a combination of differences in underlying risk factors (e.g., inflammatory bowel disease, obesity, and smoking), as well as unequal access to timely diagnostic evaluation and subspecialty care (Huang et al., 2023; Mousavi et al., 2024). Globally, higher incidence in high-income regions may in part reflect improved diagnostic capacity, whereas underdiagnosis and incomplete cancer registry data in lower-resource settings likely mask true disease burden, further widening apparent equity gaps (Huang et al., 2023).

Barriers to health equity are particularly relevant for imaging-based evaluation, as small bowel tumors often present with vague symptoms and require advanced imaging or endoscopic techniques for detection. Limited access to high-quality cross-sectional imaging, capsule endoscopy, and gastroenterology expertise in underserved or rural populations may contribute to delayed diagnosis and more advanced disease at presentation (Huang et al., 2023; Mousavi et al., 2024). Additionally, pandemic-related

disruptions disproportionately affected cancer detection in already marginalized populations, with documented declines in reported incidence likely reflecting missed or delayed diagnoses rather than true reductions in disease (Mousavi et al., 2024). Imaging guidelines should therefore be applied with awareness of these inequities, supporting timely and appropriate diagnostic imaging for patients with persistent or unexplained symptoms, particularly among groups at higher risk, to help mitigate disparities in stage at diagnosis and outcomes (Goodman et al., 2015; Huang et al., 2023).

Oncology Imaging Guidelines

Small Bowel Cancer – Restaging/ Recurrence (ONC-16.6)

ON.CC.0016.6.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Complete resection in individuals with small bowel cancer	• See Surveillance below
Recurrence suspected in individuals with small bowel cancer	• CT Chest (CPT® 71260) with contrast and CT Abdomen and Pelvis (CPT® 74177) with contrast
Unresected primary disease or metastatic disease on chemotherapy in individuals with small bowel cancer	Every 2 cycles of chemotherapy: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
Further evaluation of an inconclusive liver lesion seen on CT in individuals with small bowel cancer	• MRI Abdomen without and with contrast (CPT® 74183)
ONE of the following in individuals with small bowel cancer: • Postoperative elevated or rising CEA or LFTs with negative recent conventional imaging • Isolated metastatic lesion(s) on other imaging and individual is a candidate for aggressive surgical resection or other localized treatment to metastasis for curative intent	• PET/CT (CPT® 78815)

Background and Supporting Information

Small bowel adenocarcinoma is a rare gastrointestinal malignancy that frequently presents at an advanced stage and carries a risk of recurrence following treatment.

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Recurrence may manifest as locoregional disease or distant metastases, most commonly involving the liver, lymph nodes, peritoneum, and lungs. Accurate restaging is critical to guide management decisions, including systemic therapy or consideration of surgical intervention (NCCN, 2026).

Evidence Discussion

CT of the chest, abdomen, and pelvis with contrast is supported as the first-line imaging modality when recurrence of small bowel adenocarcinoma is suspected. Evidence demonstrates that CT provides comprehensive evaluation of the most common sites of metastatic disease, including the liver, lymph nodes, peritoneum, and lungs. This allows timely detection of recurrent or progressive disease and supports clinical decision-making, although repeated CT imaging carries risks of cumulative radiation exposure and contrast-related adverse effects (NCCN, 2026).

Serial CT imaging during systemic therapy is supported to evaluate treatment response in patients with unresected or metastatic disease. Imaging performed at defined treatment intervals enables assessment of disease progression or stability and guides decisions regarding continuation or modification of therapy. This approach improves the appropriateness of treatment selection, though it increases imaging frequency and associated risks (NCCN, 2026).

MRI of the abdomen is supported for further evaluation of inconclusive liver lesions identified on CT. Evidence indicates that MRI provides superior soft tissue contrast and improved characterization of hepatic lesions, enhancing diagnostic accuracy and facilitating assessment of resectability. This targeted use allows for more precise treatment planning while avoiding unnecessary broader imaging (NCCN, 2026).

PET/CT is supported as a problem-solving modality in select clinical scenarios, particularly when conventional imaging is negative or inconclusive despite clinical suspicion of recurrence. It may identify metabolically active disease, clarify ambiguous findings, and aid in selecting patients for aggressive interventions such as surgical resection or localized therapies with curative intent. However, limitations include false-positive findings, radiation exposure, and cost, supporting its selective rather than routine use (NCCN, 2026).

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Small Bowel Cancer – Surveillance/ Follow-up (ONC-16.7)

ON.CC.0016.7.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Stage I-III small bowel cancer	• CT Chest (CPT® 71260) with contrast and CT Abdomen and Pelvis (CPT® 74177) with contrast after completion of surgery, and then annually for 5 years
Stage IV small bowel cancer - Metastatic disease (post definitive treatment of all measurable disease, or being observed off therapy)	• CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast every 6 months for 2 years and then annually for 3 years
Measurable metastatic disease on maintenance therapy in individuals with small bowel caner	Every 3 months for up to 5 years after completion of active treatment: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)

Background and Supporting Information

Small bowel adenocarcinoma is a rare malignancy with limited disease-specific data to guide surveillance strategies. As a result, post-treatment follow-up recommendations are largely extrapolated from colorectal cancer, particularly regarding imaging intervals and modalities (NCCN, 2026).

Following curative-intent treatment, recurrence may occur locoregionally or as distant metastatic disease, most commonly involving the liver, lymph nodes, peritoneum, and lungs. Cross-sectional imaging is central to surveillance because it enables detection of asymptomatic recurrence and assessment of disease progression (NCCN, 2026).

Evidence Discussion

Surveillance imaging following treatment of small bowel adenocarcinoma is supported by the risk of recurrence and the need for early detection of treatable disease. In the absence of disease-specific evidence, imaging strategies are extrapolated from

colorectal cancer, supporting CT of the chest, abdomen, and pelvis after surgical resection and at defined intervals thereafter to detect recurrence (NCCN, 2026).

For stage I–III disease, imaging at completion of surgery followed by annual CT for five years is supported by the need to monitor for recurrence during the period of highest risk. This approach allows detection of asymptomatic disease and potential intervention, although it introduces cumulative radiation exposure and contrast-related risks over time (NCCN, 2026).

For patients with stage IV disease treated with curative intent or observed off therapy, more frequent imaging is supported to monitor for recurrence. Evidence supports CT imaging every 6 months for the first 2 years, followed by annual imaging, reflecting the higher risk of recurrence in this population and the potential benefit of early detection. Similarly, patients with measurable metastatic disease on maintenance therapy require more frequent imaging, with CT performed at shorter intervals (e.g., every 3 months) to assess disease status and guide ongoing management decisions (NCCN, 2026).

Overall, a risk-adapted surveillance strategy using CT imaging balances timely detection of recurrence with minimization of imaging-related harms. While more intensive imaging may improve detection of asymptomatic disease, the benefits must be weighed against increased radiation exposure, cost, and potential downstream interventions, supporting the guideline-recommended interval-based approach (NCCN, 2026).

Oncology Imaging Guidelines

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v1.0.2027

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Renal Cell Cancer (RCC) (ONC-17)

Guideline Page

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Renal Cell Cancer (RCC) – General Considerations (ONC-17.0)

ON.RC.0017.0.A
v1.0.2027

Criteria

- PET is considered not medically necessary for initial diagnosis, staging, restaging, or surveillance of renal cell cancer.
- A minority of adult individuals with renal cell cancer (RCC) will have translocations in TFE3 or TFEB, which have a different natural history than “adult type” RCC. Individuals of any age with TFE3 or TFEB translocated RCC should be imaged according to guidelines in **Pediatric Renal Cell Carcinoma (RCC) (PEDONC-7.4)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
- Individuals of any age with a Wilms tumor should be imaged according to guidelines in section **Unilateral Wilms Tumor (UWT) (PEDONC-7.2)** or **Bilateral Wilms Tumor (BWT) (PEDONC-7.3)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
- Oncocytoma, papillary, and chromophobe in individuals of all ages should be imaged according to these guidelines.

Background and Supporting Information

Renal cell carcinoma (RCC) represents the majority of kidney malignancies and is most commonly clear cell histology, although multiple histologic and molecular subtypes exist with differing clinical behaviors (NCCN, 2026). Prognosis is largely determined by tumor stage, grade, extent of local invasion, and the presence of metastatic disease. RCC most frequently metastasizes to the lung, bone, liver, lymph nodes, adrenal gland, and brain, which informs imaging approaches for staging and follow-up (NCCN, 2026).

Evidence Discussion

The exclusion of PET imaging for routine diagnosis, staging, restaging, and surveillance of RCC is supported by evidence demonstrating limited sensitivity and specificity compared with CT and MRI. FDG uptake in RCC is variable, and physiologic renal excretion of tracer reduces accuracy for detecting primary tumors and small lesions. As a result, PET imaging does not reliably improve diagnostic performance over standard cross-sectional imaging and is not recommended for routine use (NCCN, 2026).

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Health Equity Considerations

Significant racial, ethnic, and socioeconomic disparities persist across the renal cell carcinoma (RCC) care continuum, influencing incidence, stage at diagnosis, treatment, and survival. Black Americans experience a higher incidence of RCC and worse overall survival compared with White individuals, disparities that are largely mediated by social determinants of health rather than tumor biology alone, including lower income, lower educational attainment, higher comorbidity burden, and lower rates of insurance coverage (Alam et al., 2023; Sims et al., 2018). Hypertension and chronic kidney disease, both more prevalent and more strongly associated with RCC risk among Black individuals, account for a substantial proportion of excess RCC incidence in this population, highlighting the downstream oncologic impact of structural inequities in chronic disease prevention and management (Callahan et al., 2021). Although Black individuals may present with earlier-stage disease, survival disparities remain after adjustment for stage and histology, underscoring inequities in access to timely, high-quality diagnostic evaluation and treatment (Alam et al., 2023; Sims et al., 2018).

Geographic, ethnic, and neighborhood-level factors further shape RCC outcomes. Hispanic individuals, particularly Mexican Americans, American Indians, and Alaska Natives, are more likely to present with advanced-stage RCC and experience higher RCC-specific mortality in certain regions of the United States, with disparities amplified in medically underserved, rural, and high-poverty areas (Liu et al., 2025; Valencia et al., 2021). These inequities are closely linked to barriers in health care access, including lack of insurance, long travel distances to specialty care, and residence in lower-resource neighborhoods, rather than consistent biologic differences (Valencia et al., 2021). Imaging-based evaluation plays a critical role in RCC detection and staging; therefore, equitable application of evidence-based imaging recommendations, coupled with attention to geographic access, socioeconomic context, and comorbidity burden, is essential to reduce disparities in RCC outcomes and to ensure high-value, individual-centered care across diverse populations (Alam et al., 2023; Liu et al., 2025).

Oncology Imaging Guidelines

Renal Cell Cancer (RCC) – Suspected/ Diagnosis (ONC-17.1)

ON.RC.0017.1.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
• Solitary renal mass suspicious for renal cell cancer	• See: **Indeterminate Renal Lesion (AB-35.1)** in the Abdomen Imaging Guidelines for evaluation of suspected renal malignancies • CT Chest with contrast with (CPT® 71260) or without contrast (CPT® 71250)

Evidence Discussion

In individuals with suspected or confirmed renal cell carcinoma (RCC), complete staging includes evaluation of the chest due to the high propensity for pulmonary metastases. The lung is the most common site of distant spread, and chest imaging is therefore essential at diagnosis to evaluate for metastatic disease (Mano et al., 2015; NCCN, 2026).

Cross-sectional imaging with CT of the chest is preferred over chest radiography (CXR) because of its higher sensitivity for detecting pulmonary nodules and early metastatic disease. Studies demonstrate that pulmonary nodules are frequently identified on preoperative CT imaging, occurring in approximately half of individuals with RCC, highlighting the importance of sensitive detection methods (Mano et al., 2015).

The clinical value of CT chest imaging lies in its ability to identify nodules that may represent metastatic disease and to risk stratify patients. While many indeterminate pulmonary nodules, particularly those 1cm or less, are not associated with disease progression, larger nodules (greater than 1cm) are significantly associated with subsequent development of metastases. Thus, CT imaging not only detects disease but also provides prognostic information that can influence clinical management (Mano et al., 2015).

Despite these benefits, CT imaging introduces considerations including radiation exposure and the potential for identifying indeterminate findings that may lead to additional testing. However, the ability of CT chest to more accurately detect clinically significant pulmonary metastases compared with CXR supports its preferred use for staging in suspected RCC. Overall, the evidence supports CT chest as the medically

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necessary imaging modality for staging due to its superior diagnostic performance and ability to guide management decisions (Mano et al., 2015; NCCN, 2026).

Oncology Imaging Guidelines

Renal Cell Cancer (RCC) – Initial Work-Up/Staging (ONC-17.2)

ON.RC.0017.2.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
All individuals with RCC	If not done previously: • CT Chest with (CPT® 71260) or without (CPT® 71250) contrast • CT Abdomen and Pelvis, contrast as requested
ANY of the following in individuals with RCC: • Extension of tumor into the vena cava by other imaging • Inconclusive findings on CT	• MRI Abdomen without and with contrast (CPT® 74183)
Bone pain in individuals with RCC	• Bone scan (CPT® 78306)
EITHER of the following in individuals with RCC: • Signs/symptoms suspicious for brain metastases • Newly diagnosed stage IV/metastatic RCC	• MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Renal cell carcinoma (RCC) accounts for the majority of kidney malignancies and arises from renal cortical tissue. More than 90% of kidney cancers are RCC, and over half of cases are detected incidentally through imaging performed for unrelated indications (Campbell et al., 2021). Prognosis is primarily determined by tumor stage, grade, and histologic subtype, and early-stage disease is often associated with favorable outcomes (Campbell et al., 2021; NCCN, 2026).

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Evidence Discussion

Cross-sectional imaging with contrast-enhanced CT or MRI of the abdomen and pelvis is supported as the primary modality for initial evaluation and staging of RCC because it allows detailed characterization of renal masses and assessment of local and regional disease. Evidence demonstrates that contrast-enhanced imaging provides critical information regarding tumor enhancement, complexity, and extent, including venous invasion and nodal involvement, as well as evaluation of adjacent organs and contralateral renal function (Campbell et al., 2021; NCCN, 2026). The benefit of this approach is improved diagnostic accuracy and staging, though risks include contrast exposure and radiation with CT.

Chest imaging is supported as a necessary component of staging due to the high frequency of pulmonary metastases in RCC. CT of the chest is preferred over chest radiography because of its greater sensitivity for detecting pulmonary nodules and early metastatic disease. This improves detection of clinically significant metastases and informs treatment planning, although it may identify indeterminate findings that require further evaluation (Campbell et al., 2021; NCCN, 2026).

MRI of the abdomen is supported as an adjunct modality in cases of inconclusive CT findings or when there is concern for venous involvement, such as tumor extension into the inferior vena cava. MRI provides superior soft tissue characterization and can clarify indeterminate findings, improving staging accuracy and surgical planning. Its use is targeted due to higher cost and resource utilization compared with CT (NCCN, 2026).

Additional imaging modalities are supported selectively based on clinical findings. Bone scans are recommended in individuals with bone pain or laboratory abnormalities, as the yield of detecting osseous metastases is low in asymptomatic patients. Similarly, brain imaging is reserved for those with neurologic symptoms or known metastatic disease, as central nervous system involvement is typically symptomatic. This risk-adapted strategy minimizes unnecessary imaging while maintaining sensitivity for clinically relevant metastatic disease (Campbell et al., 2021b NCCN, 2026).

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Renal Cell Cancer (RCC) – Restaging/ Recurrence (ONC-17.3)

ON.RC.0017.3.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Unresectable disease or metastatic disease on systemic therapy in individuals with RCC	Every 2 cycles of treatment (commonly every 6 to 8 weeks): • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis, contrast as requested (CPT® 74177, CPT® 74178, or CPT® 74176) • CT with contrast of other involved or symptomatic areas
Recurrence suspected in individuals with RCC	• CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis, contrast as requested (CPT® 74177, CPT® 74178, or CPT® 74176)
EITHER of the following in individuals with RCC: • Biopsy-proven recurrent/ metastatic disease • Signs or symptoms concerning for brain metastases	• MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Renal cell carcinoma (RCC) has a well-defined pattern of metastatic spread and recurrence following initial treatment. The most common metastatic sites include the lungs, lymph nodes (retroperitoneal and mediastinal), liver, bone, and brain. Recurrence may occur locally in the renal fossa or at distant sites and is influenced by initial stage, tumor biology, and treatment approach (Campbell et al., 2021).

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Evidence Discussion

CT of the chest, abdomen, and pelvis with contrast is supported as the primary imaging modality for evaluation of suspected recurrence in RCC. Evidence demonstrates that individuals with findings concerning for recurrent or metastatic disease should undergo comprehensive imaging of the chest and abdomen to assess for disease extent, as these regions encompass the most common sites of metastasis, including lung, lymph nodes, liver, and other visceral organs (Campbell et al., 2021). This approach enables accurate restaging and informs treatment decisions, although repeated CT imaging introduces cumulative radiation exposure and contrast-related risks.

Serial CT imaging is supported in individuals with unresectable or metastatic disease receiving systemic therapy. Imaging performed at regular intervals, such as every 2 cycles of treatment, allows assessment of tumor response, stability, or progression, which is critical for determining whether to continue, modify, or change therapy. This is particularly important given the evolving treatment landscape in metastatic RCC, where immunotherapy and targeted agents require close monitoring of disease dynamics (Barragán-Carrillo et al., 2025). While beneficial for treatment optimization, this approach increases imaging frequency and associated risks.

MRI of the brain is supported in individuals with suspected or confirmed metastatic disease who have neurologic symptoms or are at risk for central nervous system involvement. Evidence indicates that brain metastases are typically symptomatic, supporting a targeted imaging approach rather than routine screening. MRI provides high sensitivity for detection of intracranial metastases and guides management decisions such as radiation therapy or systemic treatment adjustments (Campbell et al., 2021).

Overall, the imaging strategy for restaging and recurrence in RCC emphasizes comprehensive CT-based evaluation with targeted use of additional modalities based on clinical presentation. This approach balances early detection of recurrent or progressive disease with minimization of unnecessary imaging, radiation exposure, and downstream interventions while supporting timely and appropriate treatment decisions.

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Renal Cell Cancer (RCC) – Surveillance (ONC-17.4)

ON.RC.0017.4.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Renal neoplasm or suspected RCC on active surveillance of renal mass less than 1cm	ALL of the following, once within 6 months of surveillance initiation and annually thereafter: • CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, or CPT® 74150) or MRI Abdomen without and with contrast (CPT® 74183) • Chest x-ray ◦ CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250) is medically necessary instead of chest x-ray for any of the following: ▪ Known prior thoracic disease ▪ New or worsening pulmonary symptoms ▪ New or worsening chest x-ray findings For known pulmonary nodule, see **Lung Metastases (ONC-31.1)**
Renal neoplasm or suspected RCC on active surveillance of renal mass ≥1cm	ALL of the following, every 3 months for year 1, every 6 months for years 2 and 3 and annually thereafter: • CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, or CPT® 74150) OR MRI Abdomen without and with contrast (CPT® 74183) • Chest x-ray ◦ CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250) is medically necessary instead of chest x-ray for any of the following: ▪ Known prior thoracic disease ▪ New or worsening pulmonary symptoms ▪ New or worsening chest x-ray findings For known pulmonary nodule, see **Lung Metastases (ONC-31.1)**

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Indication	Medically Necessary Imaging Study
Follow up after post-ablation therapy of RCC	Annually for 5 years: • CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250) AND at 1 to 3 months, 6 months, and 12 months post-ablation and then annually thereafter: • CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, or CPT® 74150) or • MRI Abdomen without and with contrast (CPT® 74183)
Follow up in individuals with RCC after SBRT	ONE of each of the following, every 3 months for 1 year, every 6 months in year 2, every 9 months in years 3-4, and once in year 5 (to complete 5 years surveillance): • CT Chest with (CPT® 71260) or CT Chest without contrast (CPT® 71250) • CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, or CPT® 74150) or MRI Abdomen without and with contrast (CPT® 74183)
Stage I RCC, after partial or radical nephrectomy	ONE of each of the following, 3 to 12 months post-resection: • CT Chest with (CPT® 71260) or CT Chest without (CPT® 71250) contrast • CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, or CPT® 74150) or MRI Abdomen without and with contrast (CPT® 74183) ONE of each of the following, annually for 5 years: • CT Chest with (CPT® 71260) or CT Chest without (CPT® 71250) contrast • Abdominal imaging with any ONE of the following: ◦ CT Abdomen with (CPT® 74160) or without (CPT® 74150) contrast ◦ MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, or CPT® 74150)

Indication	Medically Necessary Imaging Study
Stage II RCC, post-nephrectomy	ONE of each of the following, 3 to 6 months post-resection: • CT Chest with (CPT® 71260) or CT Chest without (CPT® 71250) contrast • CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, CPT® 74150), or CT Abdomen and Pelvis, contrast as requested (CPT® 74177, CPT® 74176, or CPT® 74178), or MRI Abdomen without and with contrast (CPT® 74183) +/- MRI Pelvis without and with contrast (CPT® 72197) ONE of each of the following, every 6 months for 2 years, then annually until year 5: • CT Chest with (CPT® 71260) or CT Chest without (CPT® 71250) contrast • MRI Abdomen without and with contrast (CPT® 74183) +/- MRI Pelvis without and with contrast (CPT® 72197), or CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, or CPT® 74150), or CT Abdomen and Pelvis, contrast as requested (CPT® 74177, CPT® 74176, CPT® 74178)

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Indication	Medically Necessary Imaging Study
Stage III RCC, post-nephrectomy	ONE of each of the following, 3 to 6 months post-resection: • CT Chest with (CPT® 71260) or CT Chest without (CPT® 71250) contrast • CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, CPT® 74150), or CT Abdomen and Pelvis, contrast as requested (74177, 74176, or 74178), or MRI Abdomen without and with contrast (CPT® 74183) +/- MRI Pelvis without and with contrast (72197) ONE of each of the following, every 3 months for 3 years, then annually to year 5: • CT Chest with (CPT® 71260) or CT Chest without (CPT® 71250) contrast • CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, or CPT® 74150), or CT Abdomen and Pelvis, contrast as request (CPT® 74177, CPT® 74176, CPT® 74178), or MRI Abdomen without and with contrast (CPT® 74183) +/- MRI Pelvis without and with contrast (CPT® 72197)
Stage IV/metastatic RCC on maintenance therapy or being observed off therapy	ONE of each of the following, every 3 months for up to 5 years after completion of active treatment: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) • CT Abdomen, contrast as requested (CPT® 74170, CPT® 74160, CPT® 74150), or CT Abdomen and Pelvis contrast as requested (CPT® 74177, CPT® 74176, CPT® 74178), or MRI Abdomen without and with contrast (CPT® 74183) +/- MRI Pelvis without and with contrast (CPT® 72197) • CT with contrast of other involved or symptomatic areas

Background and Supporting Information

Renal cell carcinoma (RCC) demonstrates variable risk of recurrence following treatment, with recurrence risk strongly associated with tumor stage, grade, and other clinicopathologic factors. In patients treated with curative intent for localized disease, recurrence occurs in approximately 20%–30% of cases within 5 years, with both local and distant patterns of spread observed (Dabestani et al., 2019; NCCN, 2026).

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Surveillance strategies are designed to detect recurrence at an early and potentially curable stage, particularly for patients with limited or oligometastatic disease who may benefit from metastasis-directed therapies. However, recurrence patterns vary significantly by risk group, with low-risk patients experiencing fewer and later recurrences, and high-risk patients demonstrating earlier and more frequent recurrence (Dabestani et al., 2019).

Evidence Discussion

Surveillance imaging following treatment of RCC is supported by the risk of recurrence, particularly within the first five years after surgery, when most recurrences occur. Evidence demonstrates recurrence rates of approximately 20%–30% during this period, supporting structured follow-up protocols with imaging to detect potentially curable disease (Dabestani et al., 2019). Early detection of isolated or oligometastatic recurrence may allow for curative interventions, though the overall proportion of patients achieving long-term disease-free survival after recurrence remains limited.

Risk-adapted imaging strategies are supported by differences in recurrence patterns across disease stages. Low-risk patients have relatively low recurrence rates and later onset of recurrence, supporting less frequent imaging. In contrast, intermediate- and high-risk patients have higher and earlier recurrence rates, particularly within the first 2–3 years after surgery, supporting more intensive imaging during this period (Dabestani et al., 2019; NCCN, 2026). This stratified approach improves detection of clinically significant recurrence while minimizing unnecessary imaging in lower-risk populations.

Cross-sectional imaging with CT or MRI of the abdomen and CT or chest x-ray of the thorax is supported for surveillance due to the distribution of metastatic disease, with the lungs and abdomen representing the most common sites. Chest imaging is particularly important for detecting pulmonary metastases, while abdominal imaging allows evaluation of the renal fossa, contralateral kidney, and common visceral metastatic sites (NCCN, 2026). However, repeated imaging introduces cumulative risks, including radiation exposure, contrast toxicity, and increased healthcare utilization.

More intensive surveillance, including frequent imaging, has not consistently demonstrated improved overall survival, particularly in high-risk patients where recurrence is often multifocal and less amenable to curative treatment. Evidence indicates that while surveillance may detect recurrence earlier, this does not always translate into cure or improved long-term outcomes, especially in patients with widespread disease (Dabestani et al., 2019). Therefore, guideline-supported surveillance intervals aim to balance early detection of treatable recurrence with avoidance of excessive imaging, emphasizing a risk-based, individualized approach.

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Transitional Cell Cancer (ONC-18)

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Oncology Imaging Guidelines

Transitional Cell Cancer – General Considerations (ONC-18.0)

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Criteria

- Transitional cell cancers can include: tumors of the bladder, ureters, prostate, urethra, or renal pelvis. For primary cancer of the kidney, see: **Renal Cell Cancer (RCC) (ONC-17)**.
- The most common histology of bladder cancer is transitional cell (TCC) or urothelial carcinoma (UCC). Rare histologies include adenocarcinoma, squamous cell (imaged according to: **Transitional Cell Cancer (ONC-18)**), or small cell (imaged according to: **Extrathoracic Small Cell and Large Cell Neuroendocrine Tumors (ONC-31.8)**).
- Urachal cancer is a rare type of bladder cancer; the most common histology is adenocarcinoma. These are imaged according to muscle invasive bladder cancer.

Background and Supporting Information

Transitional cell carcinoma (TCC), also referred to as urothelial carcinoma (UCC), arises from the urothelial lining of the urinary tract and may involve the bladder, ureters, renal pelvis, urethra, or prostate. Urothelial carcinoma represents the predominant histologic subtype of bladder cancer and accounts for the majority of malignancies arising in the urinary tract epithelium (NCCN, 2026).

Bladder cancer is the most common presentation of urothelial carcinoma, with disease categorized into non-muscle-invasive bladder cancer (NMIBC), muscle-invasive bladder cancer (MIBC), and metastatic disease. These categories are clinically relevant because they reflect differences in tumor biology, risk of progression, recurrence patterns, and treatment approaches (NCCN, 2026).

Histologic subtypes beyond conventional urothelial carcinoma exist, including tumors with squamous or glandular differentiation, as well as pure non-urothelial histologies such as adenocarcinoma, squamous cell carcinoma, and neuroendocrine tumors. These variants may have different clinical behavior and may require distinct management approaches, particularly for aggressive subtypes or rare entities such as small cell carcinoma or urachal tumors (NCCN, 2026).

Health Equity Considerations

Transitional cell carcinoma (TCC) of the urinary system demonstrates marked disparities in incidence, stage at diagnosis, treatment, and survival that have important health equity implications. Population-based data from the SEER database show that

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outcomes vary substantially by anatomic location, with bladder TCC associated with earlier stage at diagnosis and more favorable survival, while upper tract urothelial carcinomas (UTUC), including renal pelvis and ureteral TCC, are more frequently diagnosed at advanced stages and have significantly worse overall and cancer-specific survival (Tang et al., 2023). These differences are not solely attributable to tumor biology but are strongly influenced by diagnostic limitations, access to timely evaluation, and challenges inherent in staging and treating upper tract disease, which may disproportionately affect older adults and medically complex patients (Tang et al., 2023).

Demographic patterns further underscore equity concerns in TCC. TCC disproportionately affects older adults and males, while racial and ethnic minority populations, including Black, Hispanic, American Indian/Alaska Native, and Asian/Pacific Islander individuals, remain underrepresented in subgroup analyses, limiting the ability to fully characterize and address disparities in these populations (Tang et al., 2023). Variations in surgical and adjuvant therapy utilization across tumor sites suggest potential differences in access to specialized care, imaging, and multidisciplinary management, particularly for UTUC, where lower rates of surgery and delayed diagnosis may worsen outcomes (Tang et al., 2023). Imaging plays a central role in detection, staging, and surveillance of TCC; therefore, equitable application of guideline-directed imaging that accounts for patient age, comorbidity burden, and anatomic site is essential to reduce disparities, support early diagnosis, and improve outcomes across all populations affected by transitional cell carcinoma (Tang et al., 2023).

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Transitional Cell Cancer – Suspected/ Diagnosis (ONC-18.1)

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- See: **Hematuria and Hydronephrosis (AB-39)** in the Abdomen Imaging Guidelines for evaluation of suspected transitional cell malignancies.

Oncology Imaging Guidelines

Transitional Cell Cancer – Initial Work-up/Staging (ONC-18.2)

ON.TS.0018.2.C
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Criteria

Indication	Medically Necessary Imaging Study
All individuals with transitional cell cancer, both muscle invasive and non-muscle invasive	ONE of the following: • CT Abdomen and Pelvis without and with contrast (CPT® 74178) ◦ MRI Abdomen (CPT® 74183) without and with contrast and MRI Pelvis (CPT® 72197) without and with contrast if contraindication to CT contrast • CT Abdomen and Pelvis without contrast (CPT® 74176) with retrograde pyelogram or renal ultrasound (CPT® 76770 or CPT® 76775) in individuals who cannot receive either CT or MRI contrast
Sessile or high-grade tumors	In addition to the imaging above, if not already performed: • MRI Pelvis without and with contrast (CPT® 72197)
ANY of the following in individuals with transitional cell cancer: • Muscle invasive bladder carcinoma • Urethral carcinoma • Urothelial carcinoma of the prostate	• CT Chest without (CPT® 71250) or with (CPT® 71260) contrast
Individuals without metastatic transitional cell cancer, when requested by operating surgeon for operative planning	• CT with contrast or MRI without and with contrast of all operative sites

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Indication	Medically Necessary Imaging Study
Evaluation of suspected bone metastasis in individuals with transitional cell cancer: • Individuals with symptoms of bone metastasis • Laboratory indicators of bone metastasis • Individuals with muscle invasive disease • Suspected sites of extra-osseous metastatic disease	Any ONE of the following: • Bone scan (CPT® 78306) • MRI without and with contrast of areas of suspected involvement • FDG PET/CT (CPT® 78815)
To evaluate inconclusive findings on conventional imaging in individuals with transitional cell cancer	• PET/CT (CPT® 78815)
Suspected brain metastases in individuals with transitional cell cancer	See: **Brain Metastases (ONC-31.3)**

Background and Supporting Information

Transitional cell carcinoma (TCC), or urothelial carcinoma (UCC), arises from the urothelial lining of the urinary tract and may involve the bladder, ureters, renal pelvis, urethra, or prostate. The disease is categorized into non–muscle-invasive and muscle-invasive forms, which differ in risk of progression, recurrence, and metastatic potential. These distinctions are central to determining appropriate imaging strategies for staging and treatment planning (NCCN, 2026).

Evidence Discussion

Cross-sectional imaging of the abdomen and pelvis with contrast is supported as the foundation of initial staging in transitional cell carcinoma because it enables comprehensive evaluation of both the upper and lower urinary tracts. CT urography provides detailed anatomic assessment, including visualization of the collecting system and detection of tumors, obstruction, or lymphadenopathy. Evidence demonstrates that multiphase CT imaging improves detection and characterization of urothelial tumors while also assessing regional and distant disease (NCCN, 2026; Coleman et al., 2023).

MRI is supported as an alternative in individuals unable to receive iodinated contrast or when further characterization is required. MRI provides excellent soft tissue contrast for local staging, particularly for evaluation of tumor invasion in sessile or high-grade lesions. However, it may be limited by motion artifact and lower sensitivity for certain

urothelial lesions compared with CT. The absence of ionizing radiation is a key benefit, particularly for patients requiring repeated imaging (NCCN, 2026).

In individuals who cannot receive either CT or MRI contrast, the combination of non-contrast imaging with retrograde pyelography or ultrasound is supported to ensure adequate evaluation of the urinary tract. Ultrasound alone is insufficient due to limited visualization of the ureters and collecting system; therefore, adjunctive techniques are required for complete assessment (NCCN, 2026; Coleman et al., 2023).

Chest imaging is supported in individuals with muscle-invasive bladder cancer or other high-risk urothelial malignancies because of the increased likelihood of pulmonary metastases. CT chest provides higher sensitivity than radiography for detecting metastatic disease, improving staging accuracy and guiding treatment decisions. Conversely, in non–muscle-invasive disease, routine chest imaging is not necessary due to low metastatic risk, supporting a risk-adapted approach (NCCN, 2026).

Additional imaging modalities are used selectively based on clinical indications. Bone imaging is supported in individuals with symptoms or laboratory evidence suggestive of osseous metastases and in those with muscle-invasive disease, reflecting the higher risk of metastatic spread. FDG PET/CT is not routinely recommended for initial staging because it does not adequately delineate urinary tract anatomy; however, it may serve as a problem-solving tool in cases of inconclusive findings on conventional imaging (NCCN, 2026).

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Transitional Cell Cancer – Restaging/ Recurrence (ONC-18.3)

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Criteria

Indication	Medically Necessary Imaging Study
After definitive surgery in individuals with transitional cell cancer	• CT Chest with contrast (CPT® 71260) AND • CT Abdomen and Pelvis with contrast (CPT® 74177) or CT Abdomen and Pelvis without and with contrast (CPT® 74178) for post-operative baseline ◦ MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast if contraindication to CT contrast
Recurrence suspicion in individuals with transitional cell cancer	• CT Chest with contrast (CPT® 71260) AND • CT Abdomen and Pelvis with contrast (CPT® 74177) or with and without contrast (CPT® 74178) ◦ MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast if contraindication to CT contrast
After neoadjuvant therapy and before resection in individuals with transitional cell cancer	• CT Chest with contrast (CPT® 71260) and CT Urogram (CPT® 74178)
Monitoring therapy for metastatic disease in individuals with transitional cell cancer	Every 2 cycles of therapy: • CT Chest with contrast (CPT® 71260) AND • CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast if contraindication to CT contrast

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Indication	Medically Necessary Imaging Study
To evaluate inconclusive findings on conventional imaging in individuals with transitional cell cancer	• PET/CT (CPT® 78815)

Background and Supporting Information

Urothelial carcinoma (transitional cell carcinoma) has a significant risk of recurrence and progression following definitive therapy, particularly in individuals with muscle-invasive disease. Recurrence may be local (pelvic or bladder bed), regional (lymph nodes), or distant, with common metastatic sites including the lungs, liver, bone, and peritoneum (Holzbeierlein et al., 2024; NCCN, 2026).

The risk of recurrence is dependent on tumor stage and pathologic features. In patients with muscle-invasive bladder cancer undergoing cystectomy, systemic recurrence rates range from approximately 20% in lower-stage disease to greater than 50% in advanced stages, and most recurrences occur within the first 2–3 years after treatment (Holzbeierlein et al., 2024).

Evidence Discussion

Cross-sectional imaging with CT of the abdomen and pelvis is supported for both baseline post-operative evaluation and assessment of suspected recurrence because it provides comprehensive visualization of the urinary tract, regional lymph nodes, and common sites of metastatic spread. Evidence indicates that CT imaging can effectively evaluate tumor extent, detect nodal disease, and identify distant metastases, which are most commonly found in lymph nodes, bone, lungs, liver, and peritoneum (Holzbeierlein et al., 2024; NCCN, 2026). This enables accurate restaging and informs management decisions, although it exposes patients to ionizing radiation and contrast-related risks.

The recommendation that restaging imaging mirrors initial staging is supported by the similar diagnostic requirements in both settings. Cross-sectional imaging remains necessary to evaluate disease burden, detect recurrence, and assess progression. Studies of imaging modalities demonstrate that CT, particularly with contrast enhancement, provides high sensitivity for identifying tumor recurrence and metastatic disease, especially when combined with multiphasic techniques that improve visualization of tumor extent and surrounding structures (Wang et al., 2004; NCCN, 2026).

Chest imaging is supported selectively in individuals with risk factors for thoracic metastases, including prior thoracic disease, pulmonary symptoms, or muscle-invasive

disease. This targeted approach reflects the higher likelihood of pulmonary involvement in advanced disease while avoiding unnecessary imaging in lower-risk patients. CT chest provides greater sensitivity than chest radiography for detection of pulmonary metastases, improving staging accuracy and treatment planning (Holzbeierlein et al., 2024).

Serial imaging during systemic therapy is supported to assess treatment response in patients with metastatic disease. Imaging performed at defined intervals, such as every 2 cycles, allows evaluation of tumor burden and guides decisions regarding continuation or modification of therapy. While this approach improves treatment monitoring, it increases the frequency of imaging and associated risks, including radiation exposure and cost (Holzbeierlein et al., 2024; NCCN, 2026).

PET/CT is supported as a problem-solving modality when conventional imaging is inconclusive. Evidence suggests that while PET/CT does not provide detailed anatomic assessment of the urinary tract and is therefore not useful for routine staging, it may help clarify equivocal findings or identify metabolically active disease. This selective use balances its diagnostic benefit with limitations including cost, radiation exposure, and reduced utility for primary tumor visualization (NCCN, 2026).

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Transitional Cell Cancer – Surveillance/ Follow-up (ONC-18.4)

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Criteria

Indication	Medically Necessary Imaging Study
ANY of the following in individuals with non-muscle invasive transitional cell carcinoma of the bladder (NMIBC): • Low risk lesions ◦ Papillary urothelial neoplasm of low malignant potential ◦ Solitary Ta lesions 3 cm or less • Intermediate risk lesions ◦ Low-grade greater than 3cm ◦ Low-grade (G1-G2) multifocal ◦ High-grade solitary Ta ≤3cm ◦ Recurrence within 1 year, low-grade Ta ◦ Low-grade T1 ◦ Any Ta Grade 2 tumor	One-time baseline imaging at the end of therapy: • CT Urogram (CPT® 74178) or MR Urogram (CPT® 74183 and CPT® 72197) • Non-contrast CT Abdomen and Pelvis (CPT® 74176) can be substituted if individual cannot receive iodinated contrast nor gadolinium • Further advanced imaging is not routinely considered medically necessary for surveillance

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Indication	Medically Necessary Imaging Study
ANY of the following high-risk non-muscle invasive transitional cell carcinoma of the bladder (high-risk NMIBC) or upper tracts: • Multifocal high-grade lesions • High-grade lesions >3cm • BCG unresponsive • Lymphovascular invasion • Prostatic urethral invasion • High-grade T1 • Any recurrent, high-grade Ta • Carcinoma in situ • Variant histologies (micropapillary, plasmacytoid, small cell/ neuroendocrine, and sarcomatoid)	• CT Urogram (CPT® 74178) or MR Urogram (CPT® 74183 and CPT® 72197) (imaging as performed at initial staging) at end of therapy, then every 1-2 years for 10 years • Non-contrast CT Abdomen and Pelvis (CPT® 74176) can be substituted if individual cannot receive iodinated contrast nor gadolinium
Non-muscle-invasive transitional carcinoma of the bladder (NMIBC) treated with cystectomy	• CT Urogram (CPT® 74178) or MR Urogram (CPT® 74183 and CPT® 72197) (imaging as performed at initial staging) at 3 and 12 months post-cystectomy, and then annually for years 2-5 • Non-contrast CT Abdomen and Pelvis (CPT® 74176) can be substituted if individual cannot receive iodinated contrast nor gadolinium
Muscle invasive lower and upper genitourinary tumors treated with cystectomy, nephrectomy, or chemoradiation	Every 3-6 months for 2 years, then annually for 3 more years: • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250), and CT Abdomen and Pelvis with contrast (CPT® 74177) or without and with contrast (CPT® 74178) OR • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250), and MR Urogram (CPT® 74183 and CPT® 72197)

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Indication	Medically Necessary Imaging Study
Measurable metastatic disease on maintenance therapy or being monitored off therapy in individuals with transitional cell cancer	Every 3 months for up to 5 years after completion of active treatment: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177), CT Urogram (CPT® 74178), or MR Urogram (CPT® 74183 and CPT® 72197) (imaging as performed at initial staging)
Urethral cancers (high-risk T1 or greater) and urothelial carcinoma of the prostate	Every 3-6 months for 2 years, then annually: • CT Abdomen and Pelvis with contrast (CPT® 74177) or without and with contrast (CPT® 74178) OR • MR Urogram (CPT® 74183 and CPT® 72197) AND • Chest x-ray ◦ CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) for any of the following: ▪ Signs/symptoms of pulmonary disease ▪ Abnormal chest x-ray ▪ Prior involvement of the chest

Background and Supporting Information

Transitional cell carcinoma (urothelial carcinoma) demonstrates a high rate of recurrence across all stages, particularly in non-muscle-invasive bladder cancer (NMIBC), where recurrence and progression risk vary significantly by tumor grade, size, and multifocality. Risk stratification into low-, intermediate-, and high-risk groups is central to determining appropriate surveillance intensity and imaging strategies (Holzbeierlein et al., 2024; NCCN, 2026).

Low-risk NMIBC is characterized by relatively high recurrence but very low rates of progression, whereas high-risk disease demonstrates both frequent recurrence and a higher likelihood of progression to muscle-invasive or metastatic disease. These differences in natural history justify a risk-adapted surveillance approach, balancing early detection of clinically significant recurrence with avoidance of unnecessary imaging (Holzbeierlein et al., 2024).

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Following definitive therapy for muscle-invasive disease, recurrence most commonly occurs within the first 2–3 years and may involve local, regional, or distant sites such as lymph nodes, lungs, liver, and bone. Surveillance imaging therefore focuses on early detection of recurrent or metastatic disease to guide timely intervention (Holzbeierlein et al., 2024; NCCN, 2026).

Evidence Discussion

A risk-adapted approach to surveillance imaging in urothelial carcinoma is supported by the heterogeneous natural history of disease. Evidence demonstrates that individuals with low-risk NMIBC have a high rate of recurrence but low likelihood of progression, supporting limited imaging beyond an initial baseline evaluation. Routine upper tract imaging is not recommended in asymptomatic individuals after baseline because the likelihood of clinically significant findings is low, and additional imaging may increase costs and unnecessary radiation exposure (Holzbeierlein et al., 2024; NCCN, 2026). In contrast, intermediate- and high-risk NMIBC are associated with increased risk of recurrence and progression, supporting periodic surveillance imaging. Evidence supports the use of CT urography or MR urography at defined intervals (e.g., every 1–2 years) to evaluate the upper urinary tract for recurrence or progression. This approach improves detection of clinically significant disease while limiting overuse of imaging in lower-risk populations (Holzbeierlein et al., 2024; NCCN, 2026).

Following definitive treatment of muscle-invasive disease, recurrence risk is highest within the first 2–3 years, justifying more intensive surveillance during this period. Cross-sectional imaging of the chest, abdomen, and pelvis enables detection of both local and distant recurrence, which may occur in lymph nodes, lungs, liver, or bone. Serial imaging at shorter intervals early in follow-up facilitates timely identification of recurrence and informs therapeutic decision-making, although it increases cumulative exposure to radiation and contrast agents (Holzbeierlein et al., 2024; NCCN, 2026).

In individuals with metastatic disease on maintenance therapy or observation, frequent imaging (e.g., every 3 months) is supported to monitor treatment response and detect progression. This allows clinicians to adjust therapy based on disease dynamics. However, this approach must balance the clinical benefit of close monitoring with the potential harms of repeated imaging, including cost, patient burden, and cumulative radiation exposure (Holzbeierlein et al., 2024; NCCN, 2026).

Chest imaging is used selectively in surveillance, particularly for individuals with higher-risk disease or symptoms suggestive of pulmonary involvement. Evidence indicates that routine chest imaging is not necessary in low-risk NMIBC but is appropriate in higher-risk groups given the increased likelihood of metastatic spread. This selective strategy optimizes diagnostic yield while minimizing unnecessary imaging (NCCN, 2026).

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Oncology Imaging Guidelines

Prostate Cancer (ONC-19)

Guideline Page

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Prostate Cancer – General Considerations (ONC-19.0)

ON.PR.0019.0.C
v1.0.2027

Criteria

- Prostate cancer screening begins at age 45 for individuals at average risk of prostate cancer. However, individuals at high-risk may begin screening at age 40. High-risk features include:
  - Black/African American identity
  - germline mutations (BRCA1 or 2, HOXB13, ATM, CHEK2, or mismatch repair genes (MLH1, MSH2, MSH6, PMS2) that increase the risk of prostate cancer
  - family history of first or second-degree relative with prostate, male breast, colorectal, pancreatic, endometrial or female breast cancer at age under 45 years
- Treatment of benign prostatic hyperplasia with 5-alfa reductase inhibitors (such as finasteride and dutasteride) can falsely reduce the measured PSA levels by 50%. Thus, the reported PSA level should be doubled when prostate cancer is suspected in individuals on these medications
- Individuals with high-risk adverse clinical and pathological factors may benefit from a more aggressive diagnostic and therapeutic approach at the time of relapse after initial treatment. These factors include pre-treatment Gleason score of 8 or higher, pre-treatment clinical stage of cT3b or higher, positive surgical margins, post-treatment PSA doubling time of less than 3 months, and an interval to biochemical failure of less than 3 years after initial treatment.
- PET/CT scans using ^{18}F-FDG radiotracer are considered not medically necessary for evaluation of prostate cancer.
- ^{11}C Choline, ^{18}F-Fluciclovine (AXUMIN®), and PSMA-specific radiopharmaceuticals have recently gained FDA approval for evaluation of prostate cancer. Optimal detection rates for these radiotracers vary greatly with PSA levels. False positive rate is high and histological confirmation of positive sites is recommended.
- PSMA-specific PET radiopharmaceuticals that are currently FDA-approved and considered medically necessary in prostate cancer are: ^{68}Ga PSMA-11 (UCSF & UCLA), ^{18}F Piflufolastat (Pylarify®), ^{18}F Flotufolastat (Posluma®), and ^{68}Ga Gozetotide (Illuccix®, Locametz®, and Gozellix®).
- MR Spectroscopy (CPT® 76390) is considered not medically necessary in the evaluation of prostate cancer at this time.
- As laser prostate ablation is considered investigational and experimental at this time, advanced imaging for treatment planning and/or surveillance of laser prostate ablation is considered not medically necessary.

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- Monitoring an elevated prostate-specific antigen level (PSA) with serial MRI is not considered medically necessary for suspected prostate cancer.
- Requests for imaging based on PSA must provide a recent PSA.

ISUP Prostate Cancer Grade Groups

Grade Group	Gleason Score	Gleason Pattern
1	≤6	≤3+3
2	7	3+4
3	7	4+3
4	8	4+4, 3+5, 5+3
5	9 or 10	4+5, 5+4, or 5+5

NCCN Initial Risk Stratification

- Low Risk
  - ALL of the following features are present:
    - Clinical T Stage = cT1-cT2a (palpable tumor limited to 1/2 or less of one side)
    - PSA (ng/mL) less than 10
    - Gleason Grade Group = 1
- Intermediate Risk
  - No "high-risk" or "very high-risk" features and one or more of the following **intermediate risk factors (IRFs)**:
    - cT2b-cT2c
    - Grade group 2 or 3
    - PSA 10-20 ng/mL
  - Favorable Intermediate Risk
    - ALL of the following features must be present:
      - Only 1 IRF
      - Gleason Grade Group = 1 or 2
      - Less than 50% biopsy cores positive (e.g., less than 6 of 12 cores)
  - Unfavorable Intermediate Risk
    - One or more of the following must be present:
      - 2 or 3 IRFs
      - Gleason grade group = 3

- 50% or more of biopsy cores positive (e.g., 6 or more of 12 cores)

- High-Risk
  - ONE or more of the following high-risk features is present:
    - Clinical T Stage = cT3-cT4
    - PSA (ng/mL) greater than 20
    - Gleason Grade Group = 4 or 5
- Very High-Risk
  - At least TWO of the following features is present:
    - Clinical T stage = cT3-cT4 (extension into the seminal vesicles or invasion into adjacent structures)
    - Primary Gleason Pattern = 5
    - Gleason Grade Group = 4 or 5
    - PSA (ng/mL) greater than 40

3D Rendering of MRI for MRI/Ultrasound Fusion Biopsy Criteria:

- When specific target lesion(s) is (are) detected on multi-parametric MRI (mpMRI) prostate and classified as PIRADS 3, 4, or 5, 3D Rendering (CPT® 76377) to generate prostate segmentation data image set for target identification on MRI/ Transrectal ultrasound (TRUS) fusion biopsy is considered medically necessary as:
  - a subsequent separate standalone request; or
  - a retrospective request for medical necessity.
- For MRI/TRUS fusion biopsy of a PIRADS 1-2 lesion, approval of 3D rendering at independent workstation (CPT® 76376 or CPT® 76377) can be considered on a case-by-case basis.
- If there is no target lesion identified on MRI, then 3D rendering and MRI/TRUS fusion biopsy is generally not considered medically necessary.
- The 3D Rendering for the TRUS component of a fusion is a part of the UroNav Fusion Equipment Software and an additional CPT® code CPT® 76377 is not considered medically necessary.

Background and Supporting Information

Prostate cancer is the most commonly diagnosed malignancy among individuals with a prostate and represents a spectrum of disease ranging from indolent tumors that may not require treatment to aggressive cancers associated with significant morbidity and mortality (NCCN, 2026). Risk stratification based on clinical stage, prostate-specific antigen (PSA), and Gleason Grade Group is fundamental to disease classification and guides diagnostic evaluation and management.

Early detection relies primarily on PSA-based screening, with digital rectal examination (DRE) used as an adjunctive tool. PSA is not cancer-specific and can be influenced

by benign conditions or medications, including 5α-reductase inhibitors, which can significantly reduce PSA levels and impact interpretation (NCCN, 2026). Screening decisions incorporate age, life expectancy, and individual risk factors such as family history, germline mutations, and ancestry.

Evidence Discussion

PSA-based screening is supported by randomized clinical trial data demonstrating a reduction in prostate cancer-specific mortality in screened populations. Trials such as the ERSPC showed a significant decrease in prostate cancer deaths among screened individuals, supporting the role of early detection in reducing disease-specific mortality. However, screening also increases detection of indolent cancers that may not require treatment, emphasizing the importance of risk stratification and shared decision-making to mitigate overtreatment (NCCN, 2026).

Identification of high-risk populations supports earlier and more targeted screening strategies. Individuals with family history, germline mutations, and Black/African American identity have higher incidence, earlier onset, and increased mortality from prostate cancer. Evidence indicates these populations may derive greater benefit from screening, justifying earlier initiation and more vigilant monitoring despite potential risks of overdiagnosis (NCCN, 2026).

PSA testing has inherent limitations that impact its clinical utility. PSA is not cancer-specific and may be elevated due to benign conditions, resulting in false-positive findings and unnecessary biopsies. Conversely, clinically significant prostate cancer can occur even at low PSA levels. Medications such as 5α-reductase inhibitors can significantly reduce PSA values, potentially masking disease if not appropriately accounted for, introducing risk for delayed diagnosis (NCCN, 2026).

Advances in imaging and diagnostic techniques, including multiparametric MRI and MRI-targeted biopsy, improve the balance of benefits and harms by increasing detection of clinically significant cancers while reducing identification of low-risk disease and unnecessary biopsies. Although newer molecular imaging modalities such as PSMA PET demonstrate improved sensitivity, their use is limited by variable detection rates and false positives, and earlier detection of recurrence has not been shown to consistently improve overall survival. These findings support a selective, risk-adapted imaging approach aligned with guideline recommendations (NCCN, 2026).

Health Equity Considerations

Prostate cancer demonstrates substantial and persistent disparities across the continuum of care, with Black men bearing a disproportionate burden of disease characterized by higher incidence, earlier onset, more aggressive tumor biology, and significantly higher mortality compared with other racial and ethnic groups (Cobbs et al., 2025; Gardner et al., 2025). These inequities are driven by an interplay of social

determinants of health, structural racism, and healthcare system barriers, including lower rates of prostate-specific antigen (PSA) screening, delayed diagnostic evaluation, reduced access to advanced imaging such as multiparametric MRI, and underutilization of targeted biopsy techniques (Cobbs et al., 2025; Gardner et al., 2025). Socioeconomic status, insurance coverage, geographic location, and medical mistrust further compound these challenges, contributing to later-stage diagnoses and limiting opportunities for curative intervention, particularly among Black men, rural populations, and individuals with lower income or educational attainment (Gardner et al., 2025).

Disparities also extend into treatment selection, imaging surveillance, and access to precision medicine. Black men and other underserved populations are less likely to receive guideline-concordant imaging, definitive local therapy, advanced radiation modalities, and emerging theranostic or radiogenomic approaches, despite evidence that outcomes are comparable, or sometimes superior, when care is delivered in equal-access systems (Cobbs et al., 2025; Gardner et al., 2025). Underrepresentation of racial and ethnic minorities in clinical trials and genomic databases limits the generalizability of evidence used to guide imaging and treatment decisions, potentially reinforcing inequities as novel technologies are adopted (Cobbs et al., 2025). Equitable implementation of prostate cancer imaging emphasizing risk-adapted screening, timely diagnostic imaging, culturally competent patient engagement, and consistent access to advanced technologies is essential to reducing disparities and improving outcomes across diverse populations (Cobbs et al., 2025; Gardner et al., 2025).

Oncology Imaging Guidelines

Suspected Prostate Cancer (ONC-19.1)

ON.PR.0019.1.A
v1.0.2027

Criteria

Oncology Imaging Guidelines

Indication	Medically Necessary Imaging Study
ANY of the following: • Age 45-75* years and ONE of the following: ◦ PSA >3ng/ml ◦ Very suspicious DRE *For individuals with any of the following risk factors, screening may begin at age 40: • Black/African American ancestry • Germline mutations that increase the risk of prostate cancer • Family history of first- or second-degree relative with prostate, male breast, pancreatic, or ovarian cancer • Family history of two or more first-degree relatives diagnosed at any age with colorectal, endometrial, breast, or prostate cancer • Family history of first- or second-degree relative diagnosed at age ≤45 years with female breast cancer • Family history of first- or second-degree relative diagnosed at age ≤50 years with colorectal or endometrial cancer • Age >75 years and ONE of the following: ◦ PSA ≥4ng/ml ◦ Very suspicious DRE • At least one negative/non-diagnostic TRUS biopsy and ANY of the following: ◦ Rising PSA ◦ Abnormal DRE ◦ Need for confirmatory MR/US fusion biopsy	ANY of the following: • Transrectal ultrasound (CPT® 76872) • TRUS-guided biopsy (CPT® 76942) • MRI/US fusion biopsy (CPT® 76942) • MRI Pelvis without and with contrast (CPT® 72197) or without contrast (CPT® 72195)
• PIRADS 3, 4, or 5 lesion identified on recent diagnostic MRI Pelvis (CPT® 72195 or CPT® 72197) and planning for biopsy to be done by MRI/TRUS fusion technique	• 3D Rendering (CPT® 76376 or CPT® 76377)

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Indication	Medically Necessary Imaging Study
ANY of the following: • Multifocal (2 or more lesions) high-grade prostatic intraepithelial neoplasia (PIN) • Atypia on biopsy	• Extended pattern re-biopsy within 6 months by TRUS-guided biopsy (CPT® 76942)
• Solitary PIN (1 lesion)	ONE of the following, to be repeated in one year: • MRI Pelvis without contrast (CPT® 72195) • MRI Pelvis without and with contrast (CPT® 72197) • MRI/US fusion biopsy (CPT® 76942 or 76872) ◦ These codes are medically necessary in addition to MR Pelvis codes above, if requested
In office, transperineal, MRI guided biopsy without US fusion (i.e., ProMaxo)	Neither MRI CPT® 77021 nor 76498 are medically necessary in conjunction with procedure codes. MRI is bundled in with the procedure code.
An existing MRI cannot be used for MRI/US fusion biopsy	Unlisted MRI code (CPT® 76498)

Background and Supporting Information

Prostate cancer is commonly detected through early evaluation strategies incorporating prostate-specific antigen (PSA) testing and digital rectal examination (DRE). PSA is a serum biomarker produced by prostate epithelial cells, and although not cancer-specific, increasing PSA levels correlate with higher likelihood of malignancy. Clinical suspicion is heightened by abnormal DRE findings, rising PSA trends, or persistently elevated PSA following prior negative biopsy (NCCN, 2026).

Risk stratification for suspected prostate cancer incorporates patient age, PSA level, DRE findings, and clinical risk factors, including family history and germline mutations. Individuals with elevated PSA or abnormal DRE require further diagnostic evaluation to

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identify clinically significant disease while minimizing unnecessary procedures (NCCN, 2026).

Evidence Discussion

Clinical evaluation of suspected prostate cancer is supported by evidence demonstrating that PSA levels and DRE findings are associated with the likelihood of clinically significant malignancy. Increasing PSA levels correlate with a higher probability of prostate cancer, and abnormal DRE findings may identify tumors independent of PSA level. However, PSA lacks specificity, as elevations may occur in benign conditions, which can lead to unnecessary biopsies and patient anxiety (NCCN, 2026).

Imaging with multiparametric MRI is supported as an important adjunct in the diagnostic pathway. MRI improves detection and localization of clinically significant tumors and enhances patient selection for biopsy. Evidence demonstrates that MRI-targeted biopsy techniques increase detection of higher-grade disease while reducing identification of low-risk disease, thereby improving diagnostic accuracy and limiting overdiagnosis (NCCN, 2026).

Transrectal ultrasound-guided biopsy and MRI/ultrasound fusion biopsy are supported for tissue diagnosis in individuals with suspected prostate cancer. Targeted biopsy approaches improve sampling of suspicious lesions and are particularly beneficial in patients with prior negative biopsy and persistent clinical concern. These approaches increase detection of clinically significant cancer while reducing the number of unnecessary repeat biopsies (NCCN, 2026).

Repeat imaging and biopsy strategies in individuals with atypia, high-grade prostatic intraepithelial neoplasia, or persistently abnormal clinical findings are supported by evidence showing an increased risk of subsequent cancer detection in these populations. Structured follow-up with MRI and/or repeat biopsy allows for timely identification of clinically significant disease, though repeated procedures carry risks including infection, bleeding, and patient burden. Overall, the use of risk-based imaging and biopsy strategies balances improved cancer detection with minimization of unnecessary interventions (NCCN, 2026).

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Prostate Cancer – Initial Work-up/ Staging (ONC-19.2)

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v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Localized prostate cancer with any of the following risk groups (see: **Prostate Cancer – General Considerations (ONC-19.0)** for definition of risk groups): • Low risk • Favorable intermediate risk	Advanced imaging is not routinely considered medically necessary for initial staging. If not already performed prior to biopsy, MRI Pelvis without and with contrast (CPT® 72197) is considered medically necessary for any of the following: • Prior to planned treatment (surgery and/ or radiation therapy) • To establish candidacy for active surveillance

Oncology Imaging Guidelines

Indication	Medically Necessary Imaging Study
Localized prostate cancer with any of the following risk groups (see: **Prostate Cancer – General Considerations (ONC-19.0)** for definition of risk groups): • Unfavorable intermediate risk • High-risk • Very high-risk	Any ONE of the following combinations, not all (may be obtained in addition to mpMRI prostate): • CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT® 78306) • CT Chest with contrast (CPT® 71260), CT Abdomen with contrast (CPT® 74160), MRI Pelvis without and with contrast (CPT® 72197) if not previously performed, and Bone scan (CPT® 78306) • PSMA PET/CT scan (CPT® 78815 or CPT® 78816) or PSMA PET/MRI (CPT® 78813 and CPT® 76498) using any one of the following radiotracers: ◦ ^{68}Ga-PSMA-11 ◦ ^{18}F Piflufolastat (Pylarify®) ◦ ^{68}Ga Gozetotide (Illuccix®, Locametz®, and Gozellix®) ◦ ^{18}F Flotufolastat (Posluma®) *If initial CT or MRI of chest/abdomen/pelvis and bone scan is negative or inconclusive but there remains a significant clinical suspicion for metastatic disease (i.e., continued increase in PSA or symptoms of bony metastatic disease), PSMA PET/CT (CPT® 78815 or CPT® 78816) or PET/MRI (CPT® 78813 and CPT® 76498) is considered medically necessary.

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Indication	Medically Necessary Imaging Study
To confirm oligo- or low volume metastatic prostate cancer suspected on conventional imaging in individuals with biopsy-proven prostate cancer	• PSMA PET/CT (CPT® 78815 or CPT® 78816) or PSMA PET/MRI (CPT® 78813 and CPT® 76498) with any of the following radiotracers: ◦ ^{68}Ga-PSMA-11 ◦ ^{18}F Piflufolastat (Pylarify®) ◦ ^{18}F Flotufolastat (Posluma®) ◦ ^{68}Ga Gozetotide (Illuccix®, Locametz®, and Gozellix®)
Known diffuse metastatic prostate cancer (including prior to prostate biopsy) (In obvious diffuse metastatic prostate cancer based on other imaging, PSMA PET is not medically necessary)	Any ONE of the following combinations, not all: • CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT 78306) • CT Chest with contrast (CPT® 71260), CT Abdomen with contrast (CPT® 74160), MRI Pelvis without and with contrast (CPT® 72197) if not previously performed, and Bone scan (CPT® 78306
Inconclusive bone scan in individuals with prostate cancer	Any ONE of the following: • CT with contrast of involved body site • MRI without and with contrast of involved body site • PET/CT (CPT® 78815 or CPT® 78816) or PET/MRI (CPT® 78813 and CPT® 76498) using any one of the following radiotracers: ◦ ^{18}F Fluciclovine ◦ ^{11}C Choline ◦ ^{68}Ga-PSMA-11 ◦ ^{18}F Piflufolastat (Pylarify®) ◦ ^{18}F Flotufolastat (Posluma®) ◦ ^{68}Ga Gozetotide (Illuccix®, Locametz®, and Gozellix®) ◦ ^{18}F sodium fluoride

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Indication	Medically Necessary Imaging Study
If pathology or clinical scenario suggests neuroendocrine-predominant prostate cancer	See: **Extrathoracic Small Cell and Large Cell Neuroendocrine Tumors (ONC-31.8)**

At present, neither the AUA guidelines nor NCCN guidelines consider cribriform histology and/or perineural invasion as standalone risk factors that move individuals into an unfavorable intermediate risk or higher group.

Background and Supporting Information

Prostate cancer is stratified into risk groups based on clinical stage, prostate-specific antigen (PSA), and histologic grade (Gleason Grade Group), which together guide staging evaluation and treatment planning. These risk groups range from low risk to very high risk and reflect the probability of local advancement, nodal involvement, and distant metastases (NCCN, 2026).

In clinically localized disease, the likelihood of metastatic spread varies significantly by risk category. Low-risk and favorable intermediate-risk disease are associated with a very low probability of metastatic involvement, while unfavorable intermediate-, high-, and very high-risk disease demonstrate increased risk of regional and distant metastases, including bone and visceral sites (NCCN, 2026).

Evidence Discussion

Risk stratification using PSA, clinical stage, and Gleason Grade Group is supported as the foundation for determining appropriate imaging in newly diagnosed prostate cancer. Evidence demonstrates that individuals with low-risk or favorable intermediate-risk disease have a very low likelihood of metastatic disease, and routine advanced imaging in these populations offers limited diagnostic yield. As a result, omitting advanced imaging in these groups reduces unnecessary radiation exposure, cost, and false-positive findings without compromising clinical outcomes (NCCN, 2026).

Multiparametric MRI is supported for local staging and treatment planning, particularly prior to definitive therapy or when considering active surveillance. MRI provides superior soft tissue characterization compared with CT and improves identification of extracapsular extension and other adverse local features. This improves risk stratification and helps guide clinical decision-making, though it may be limited by availability, cost, and variability in interpretation (NCCN, 2026).

In individuals with unfavorable intermediate-, high-, or very high-risk disease, cross-sectional imaging and bone imaging are supported due to the increased likelihood of metastatic spread. CT of the chest, abdomen, and pelvis and bone scans allow

detection of nodal and skeletal metastases, which are critical for staging and treatment selection. The use of these modalities improves staging accuracy and helps direct appropriate systemic or locoregional therapy, although they are associated with radiation exposure and potential contrast-related risks (NCCN, 2026).

PSMA PET imaging is supported as an alternative or adjunct to conventional imaging due to its higher sensitivity for detecting metastatic and small-volume disease. Evidence indicates that PSMA PET can identify lesions not detected on conventional imaging and may clarify equivocal findings. However, it is not routinely required in all patients, as its impact on long-term survival outcomes remains uncertain and false-positive findings may occur, necessitating cautious interpretation and potential confirmatory testing (NCCN, 2026).

Additional imaging is supported in cases of inconclusive findings or when clinical suspicion for metastatic disease persists despite negative conventional imaging. Modalities such as CT, MRI, or advanced PET tracers may further characterize suspicious lesions and guide management decisions. This stepwise, risk-adapted imaging approach balances improved diagnostic accuracy with minimization of unnecessary imaging and associated harms (NCCN, 2026).

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Prostate Cancer – Restaging/Recurrence (ONC-19.3)

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v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
For ANY of the following in individuals with prostate cancer: • Obvious progression by DRE with plans for prostatectomy or radiation therapy • Repeat TRUS biopsy for rising PSA shows progression to a higher Gleason's score with plans for prostatectomy or radiation therapy • Inconclusive findings on CT scan	• MRI Pelvis without and with contrast (CPT® 72197)
Non-metastatic prostate cancer previously treated with ablation, hormonal therapy, or chemotherapy **and** any one of the following: • Clinical suspicion of relapse/recurrence • Palpable anastomotic recurrence • PSA rises above post-treatment baseline to >0.2 ng/mL on two consecutive measurements	Any ONE of the following combinations (may be obtained in addition to mpMRI Prostate): • CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT® 78306) • CT Chest with contrast (CPT® 71260), CT Abdomen with contrast (CPT® 74160), MRI Pelvis without and with contrast (CPT® 72197), and Bone scan (CPT® 78306)

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Indication	Medically Necessary Imaging Study
Non-metastatic prostate cancer previously treated with prostatectomy and **all** of the following are met: • Persistent detectable PSA after prostatectomy, or • Undetectable PSA that subsequently becomes detectable with two consecutive increases in PSA (to any amount), or • Any increase in PSA to 0.1 ng/mL or higher	Any ONE of the following: • PSMA PET/CT scan (CPT® 78815 or CPT® 78816) or PET/MRI (CPT® 78813 and CPT® 76498) with any of the following radiotracers: ◦ ^{68}Ga-PSMA-11 ◦ ^{18}F Piflufolastat (Pylarify®) ◦ ^{18}F Flotufolastat (Posluma®) ◦ ^{68}Ga Gozetotide (Illuccix®, Locametz®, and Gozellix®) • CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT® 78306) • CT Chest with contrast (CPT® 71260), CT Abdomen with contrast (CPT® 74160), MRI Pelvis without and with contrast (CPT® 72197), and Bone scan (CPT® 78306)

Indication	Medically Necessary Imaging Study
Non-metastatic prostate cancer previously treated with radiation therapy and two consecutive increases in PSA above nadir	Any ONE of the following: • PSMA PET/CT scan (CPT® 78815 or CPT® 78816) or PET/MRI (CPT® 78813 and CPT® 76498) with any of the following radiotracers: ◦ ^{68}Ga-PSMA-11 ◦ ^{18}F Piflufolastat (Pylarify®) ◦ ^{18}F Flotufolastat (Posluma®) ◦ ^{68}Ga Gozetotide (Illuccix®, Locametz®, and Gozellix®) • CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT® 78306) • CT Chest with contrast (CPT® 71260), CT Abdomen with contrast (CPT® 74160), MRI Pelvis without and with contrast (CPT® 72197), and Bone scan (CPT® 78306)
Non-metastatic prostate cancer previously treated with prostatectomy or radiation therapy, and **all** of the following are met: • PSA rises on two consecutive measurements above post-treatment baseline **and** • PSA ≥1 ng/mL **and** • Recent CT scan and bone scan are negative for metastatic disease	• PET/CT scan (CPT® 78815 or CPT® 78816) or PET/MRI (CPT® 78813 and CPT® 76498) using any **ONE** of the following radiotracers: ◦ ^{18}F-Fluciclovine ◦ ^{11}C Choline
Suspected progression of known metastatic prostate cancer based on: • New or worsening signs/symptoms • Rising PSA levels	• CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT® 78306) • CT with contrast of any involved or symptomatic body part

Indication	Medically Necessary Imaging Study
Metastatic prostate cancer receiving treatment with chemotherapy or Pluvicto®	One of the following combinations, every 2 cycles (6 to 8 weeks), while on chemotherapy: • CT Abdomen and Pelvis with contrast (CPT® 74177) and CT scan with contrast of any involved body part • CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250) OR • CT Abdomen with contrast (CPT® 74160), MRI Pelvis without and with contrast (CPT® 72197) AND, every 3-6 months: • Bone scan (CPT® 78306) If any of the above conventional imaging studies are inconclusive: • PSMA PET/CT scan (CPT® 78815 or CPT® 78816) or PET/MRI (CPT® 78813 and CPT® 76498) and/or • SPECT/CT (CPT® 78830 or 78832)
Metastatic prostate cancer receiving anti-androgen therapy	One of the following combinations, every 3 months, while on anti-androgen therapy: • CT Abdomen and Pelvis with contrast (CPT® 74177) and CT scan of any involved body part • CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250) OR • CT Abdomen with contrast (CPT® 74160), MRI Pelvis without and with contrast (CPT® 72197) AND, every 3-6 months: • Bone scan (CPT® 78306)

Indication	Medically Necessary Imaging Study
Active metastatic prostate cancer with evidence of progression (clinical/ PSA/conventional imaging) and being considered for ^{177}Lu-PSMA-617 (Pluvicto®) treatment	ANY or ALL of the following: • PSMA PET/CT scan (CPT® 78815 or CPT® 78816) or PET/MRI (CPT® 78813 and CPT® 76498) with one of the following agents: ◦ ^{68}Ga PSMA-11 ◦ ^{18}F Piflufolastat (Pylarify®) ◦ ^{68}Ga Gozetotide (Illucix®, Locametz®, and Gozellix®) ◦ ^{18}F Flotufolastat (Posluma®) • The combination of: ◦ CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250), CT Abdomen with contrast (CPT® 74160), MRI Pelvis without and with contrast (CPT® 72197), and Bone scan (CPT® 78306) **OR** ◦ CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT® 78306) *While PSMA PET is considered medically necessary to determine candidacy for Pluvicto®, it is not considered medically necessary for restaging on Pluvicto®; thus, baseline conventional imaging is considered medically necessary in addition to baseline PSMA PET/CT or PET/MRI.

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Indication	Medically Necessary Imaging Study
Non-metastatic prostate cancer treated with prostatectomy or radiation therapy who do not meet ALL above criteria for PSMA PET/CT but have clinical signs/ symptoms of recurrence	Any ONE of the following combinations: • CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT® 78306) • CT Chest with contrast (CPT® 71260), CT Abdomen with contrast (CPT® 74160), MRI Pelvis without and with contrast (CPT® 72197), and Bone scan (CPT® 78306)
Prior to start of Xofigo® (Radium-223) therapy in individuals with prostate cancer	• ONE time CT Chest, Abdomen and Pelvis with contrast (CPT® 71260 and CPT® 74177)
Inconclusive bone scan or negative bone scan with inconclusive CT or MRI in individuals with prostate cancer	Any ONE of the following: • CT with contrast of involved body site • MRI without and with contrast of involved body site • PET/CT (CPT® 78815 or CPT® 78816) or PET/MRI (CPT® 78813 and CPT® 76498) using any one of the following radiotracers: ◦ ^{18}F Fluciclovine ◦ ^{11}C Choline ◦ ^{68}Ga-PSMA-11 ◦ ^{18}F Piflufolastat (Pylarify®) ◦ ^{18}F Flotufolastat (Posluma®) ◦ ^{68}Ga Gozetotide (Illuccix®, Locametz®, and Gozellix®) ◦ ^{18}F sodium fluoride

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Indication	Medically Necessary Imaging Study
Conventional imaging studies (CT and bone scan) suggests oligo- or low volume metastatic disease that needs further confirmation in individuals with prostate cancer	• PET/CT scan (CPT® 78815 or CPT® 78816) or PET/MRI (CPT® 78813 and CPT® 76498) using any one of the following radiotracers: ◦ ^{18}F Fluciclovine ◦ ^{11}C Choline ◦ ^{68}Ga-PSMA-11 ◦ ^{18}F Piflufolastat (Pylarify®) ◦ ^{68}Ga Gozetotide (Illuccix®, Locametz®, and Gozellix®) ◦ ^{18}F Flotufolastat (Posluma®)
If pathology or clinical scenario suggests neuroendocrine-predominant disease	See: **Extrathoracic Small Cell and Large Cell Neuroendocrine Tumors (ONC-31.8)**

Background and Supporting Information

Prostate cancer recurrence and progression are most commonly identified through rising prostate-specific antigen (PSA) levels, abnormal digital rectal examination (DRE), or imaging findings following definitive therapy. PSA kinetics, including persistence after prostatectomy or rising levels after radiation therapy, serve as sensitive indicators of biochemical recurrence and guide further diagnostic evaluation (NCCN, 2026).

Patterns of recurrence may include local recurrence within the prostate bed or pelvis, regional lymph node involvement, or distant metastatic disease, most frequently involving bone and visceral organs. Imaging strategies are tailored based on the likelihood of recurrence, disease burden, and prior treatment modality (NCCN, 2026).

Evidence Discussion

The use of PSA levels and clinical findings such as DRE abnormalities is supported as a primary trigger for restaging imaging in suspected recurrent prostate cancer. Evidence demonstrates that rising PSA after definitive therapy, including PSA persistence or biochemical recurrence, is strongly associated with disease recurrence and warrants further imaging evaluation to localize disease and guide treatment planning (NCCN, 2026).

Conventional imaging with CT of the chest, abdomen, and pelvis and bone scan remains the standard approach for evaluating recurrent or progressive prostate cancer, particularly in patients with higher PSA levels or symptoms suggestive of metastatic involvement. CT provides detailed anatomic assessment of nodal and visceral disease, while bone scan is effective for detecting skeletal metastases, the most common site of

spread. These modalities are widely available and provide a comprehensive overview of disease burden, although sensitivity may be limited for small-volume or early metastatic disease (NCCN, 2026).

PSMA PET imaging is supported for evaluation of biochemical recurrence due to its improved sensitivity and specificity compared with conventional imaging. Evidence indicates that PSMA-targeted radiotracers can detect micrometastatic disease at lower PSA levels and may be used without prerequisite conventional imaging in certain post-prostatectomy settings. This improved detection can influence treatment planning, including the identification of candidates for localized or systemic therapy. However, limitations include potential false-positive findings and limited evidence regarding impact on long-term survival outcomes. PSMA PET/CT and/or SPECT/CT is not supported in the absence of equivocal conventional imaging. While there is emerging data regarding use of SPECT/CT for restaging on therapy with Pluvicto®, neither the NCCN nor AUA nor SNMMI provide guidance for its use in routine restaging in this setting (NCCN, 2026).

In individuals with metastatic disease or suspected progression based on symptoms or rising PSA, serial imaging is supported to assess treatment response and disease progression. Conventional imaging remains the standard for monitoring during systemic therapy, with CT and bone scan performed at defined intervals. Advanced imaging modalities are generally reserved for equivocal findings or specific clinical scenarios, balancing improved diagnostic accuracy with the risks of increased cost, radiation exposure, and uncertain impact on outcomes (NCCN, 2026).

Oncology Imaging Guidelines

Prostate Cancer – Follow-up On Active Surveillance (ONC-19.4)

ON.PR.0019.4.A
v1.0.2027

Criteria

Current active surveillance guidelines suggest the following protocol:

- PSA every 6 months
- Digital Rectal Exam (DRE) every 12 months
- Repeat prostate biopsy every 12 months
- Repeat mpMRI (CPT® 72195 or CPT® 72197) no more often than every 12 months

Indication	Medically Necessary Imaging Study
Routine monitoring in individuals with prostate cancer on active surveillance protocol	• MRI Pelvis without (CPT® 72195) or without and with contrast (CPT® 72197) at initiation of active surveillance, and every 12 months thereafter
Planning for re-biopsy to be done by MRI/US fusion technique in individuals with prostate cancer	• 3D Rendering (CPT® 76376 or CPT® 76377)
For ANY of the following in individuals with prostate cancer: • Progression is suspected based on DRE changes or rising PSA and a recent TRUS biopsy was negative • Repeat TRUS biopsy shows progression to a higher Gleason score	• MRI Pelvis without (CPT® 72195) or MRI Pelvis without and with contrast (CPT® 72197)
Individuals with prostate cancer on active surveillance who are noted to have progression and have plans to initiate treatment	• Imaging studies for initial staging as per **ONC-19.2**

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Background and Supporting Information

Active surveillance is a management strategy for individuals with low-risk prostate cancer that involves regimented monitoring for disease progression without specific anticancer treatment. It is designed to defer or avoid treatment-related morbidity while maintaining the opportunity for curative intervention if disease progression occurs. This approach is appropriate for carefully selected individuals with favorable disease characteristics and sufficient life expectancy (NCCN, 2026).

Active surveillance is distinct from observation (watchful waiting), which is generally reserved for individuals with limited life expectancy. Watchful waiting involves cessation of routine monitoring, and treatment is initiated only if symptoms develop. In contrast, active surveillance includes scheduled follow-up to detect disease progression at a stage when curative treatment remains feasible (NCCN, 2026).

Evidence Discussion

Active surveillance protocols are supported by evidence demonstrating that many individuals with low-risk prostate cancer have indolent disease that may not require immediate treatment. Close monitoring with PSA, DRE, biopsy, and imaging allows identification of disease progression while avoiding unnecessary interventions and associated morbidity. This strategy reduces overtreatment and preserves quality of life without compromising oncologic outcomes in appropriately selected individuals (NCCN, 2026).

Multiparametric MRI is supported as part of routine monitoring due to its ability to improve detection of clinically significant disease and guide targeted biopsy. MRI enhances visualization of tumor location and extent, increasing the likelihood of identifying progression that may warrant a change in management. However, MRI should be used at appropriate intervals to limit cost, resource utilization, and potential overdiagnosis of indolent findings (NCCN, 2026).

Routine metastatic staging imaging is not supported during active surveillance in the absence of clinical progression, as the probability of metastatic disease in low-risk populations is very low. Avoiding unnecessary imaging reduces radiation exposure, false-positive findings, and downstream interventions without adversely impacting outcomes (NCCN, 2026).

When progression is suspected based on rising PSA, abnormal DRE, or biopsy upgrading, imaging plays a role in reassessment and treatment planning. At this point, imaging follows principles used in initial staging to accurately characterize disease extent and guide definitive management. This stepwise escalation in imaging intensity balances early detection of clinically meaningful progression with minimization of unnecessary diagnostic procedures (NCCN, 2026).

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Surveillance/Follow-up For Treated Prostate Cancer (ONC-19.5)

ON.PR.0019.5.C
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
An individual with ALL of the following in individuals with prostate cancer: • Asymptomatic or stable chronic symptoms • Stable DRE findings • Stable PSA levels	• Advanced imaging not routinely considered medically necessary for surveillance
An individual with ANY of the following in individuals with prostate cancer: • New or worsening symptoms • Change in DRE findings • Rising PSA	ANY of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Pelvis without contrast (CPT® 72195) or without and with contrast (CPT® 72197)

Background and Supporting Information

Following definitive treatment of prostate cancer, ongoing surveillance focuses on monitoring for recurrence or progression using prostate-specific antigen (PSA), digital rectal examination (DRE), and clinical assessment. PSA is a highly sensitive marker for detecting biochemical recurrence, and trends over time guide further diagnostic evaluation and management (NCCN, 2026).

Surveillance strategies are tailored based on initial risk group, treatment modality, and patient-specific factors. In individuals with stable PSA values, normal or unchanged DRE findings, and absence of symptoms, the likelihood of clinically significant recurrence is low. Therefore, routine follow-up emphasizes clinical and laboratory monitoring rather than imaging (NCCN, 2026).

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Evidence Discussion

In individuals with treated prostate cancer who are asymptomatic and demonstrate stable PSA levels and DRE findings, evidence supports that advanced imaging is not routinely necessary. PSA is highly sensitive for identifying recurrence, and stable PSA trends are associated with a low likelihood of clinically significant disease, making routine imaging of limited value in this population (NCCN, 2026).

Avoiding routine advanced imaging in this context reduces potential harms, including unnecessary radiation exposure, contrast-related risks, false-positive findings, and downstream invasive procedures. These risks are particularly relevant given the low pretest probability of recurrence in individuals with stable clinical and laboratory findings (NCCN, 2026).

Clinical observation using PSA monitoring and DRE allows timely identification of changes that may warrant further evaluation. Evidence demonstrates that rising PSA or new clinical findings are reliable indicators for recurrence, at which point imaging can be appropriately escalated to localize disease and guide treatment decisions (NCCN, 2026).

Overall, a surveillance strategy that relies on clinical and biochemical monitoring with selective use of imaging provides an optimal balance between early detection of recurrence and minimization of unnecessary testing. This approach aligns with guideline recommendations to avoid overuse of imaging in low-risk clinical scenarios while maintaining the ability to intervene promptly when progression is suspected (NCCN, 2026).

Oncology Imaging Guidelines

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Testicular, Ovarian, and Extragonadal Germ Cell Tumors (ONC-20)

Guideline Page

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Testicular, Ovarian, and Extragonadal Germ Cell Tumors – General Considerations (ONC-20.0)

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v1.0.2027

Criteria

- This section applies to primary germ cell tumors occurring outside the central nervous system for individuals older than the age of 15 years at the time of initial diagnosis. Individuals 15 years of age or younger at diagnosis should be imaged according to pediatric guidelines in: **Pediatric Germ Cell Tumors (PEDONC-10)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
- These guidelines are for germ cell tumors of the testicle, ovary and extragonadal sites as well as malignant sex cord stromal tumors.
- Requests for imaging must state the histologic type of the cancer being evaluated.
- Classified as seminoma/dysgerminoma, non-seminomatous germ cell tumors (NSGCT), or mixed.
  - Dysgerminoma is the ovarian equivalent of seminoma. There is no testicular dysgerminoma.
  - Mixed tumors are treated as NSGCTs, as they tend to be more aggressive.
  - Germ Cell Tumors include:
    - Teratomas
    - Yolk sac tumors
    - Choriocarcinomas
    - Embryonal carcinomas
    - Mixed germ cell tumors
    - Dysgerminoma
  - Sex Cord Stromal Tumors include:
    - Granulosa Cell Tumor (juvenile/adult)
    - Fibroma/Fibrosarcoma
    - Thecoma
    - Levdig Cell Tumor
    - Sertoli Cell Tumor
    - Mixed (Sertoli-Levdig, Gynadroblastoma)
- MRI in place of CT scans to reduce risk of secondary malignancy is not supported by the peer-reviewed literature. CT scans are considered medically necessary for surveillance and are the preferred modality of imaging to assess for recurrence.

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- PET/CT is considered not medically necessary for evaluation of non-seminomatous germ cell tumors.

Background and Supporting Infomraiton

Germ cell tumors (GCTs) arise from primordial germ cells and may occur in the gonads (testes and ovaries) or at extragonadal sites such as the mediastinum or retroperitoneum. These tumors include a spectrum of histologies, broadly categorized into seminomatous tumors (seminoma in males and dysgerminoma in females) and non-seminomatous germ cell tumors (NSGCTs), which include embryonal carcinoma, yolk sac tumor, choriocarcinoma, teratoma, and mixed histologies (NCCN, 2025; NCCN, 2026).

Classification of germ cell tumors into seminoma/dysgerminoma and non-seminomatous subtypes is supported by evidence demonstrating distinct biologic behavior, treatment response, and prognosis. Seminomatous tumors are generally more radiosensitive and have a more predictable pattern of spread, while NSGCTs are more aggressive and heterogeneous, requiring different imaging and treatment approaches. This distinction supports histology-driven imaging and management strategies to optimize outcomes (NCCN, 2025).

Malignant germ cell tumors of the ovary and testis, as well as extragonadal germ cell tumors, are highly curable, particularly when diagnosed at an early stage. Management strategies include surgery, systemic therapy, and surveillance depending on histology, stage, and risk factors. Imaging plays a central role in staging, treatment planning, and follow-up, with cross-sectional imaging used to evaluate disease extent and monitor response (NCCN, 2025; NCCN, 2026).

Evidence Discussion

Cross-sectional imaging with CT or MRI is supported as a central component of staging and follow-up due to its ability to evaluate the retroperitoneum, pelvis, and thorax, which are common sites of metastatic spread. CT is widely utilized because of its accessibility and ability to detect nodal and visceral disease, and it remains the preferred modality for surveillance despite concerns regarding cumulative radiation exposure. MRI may be used as an alternative in selected cases but has not demonstrated clear superiority for routine surveillance (NCCN, 2025).

PET/CT imaging has a limited role and is not routinely recommended in non-seminomatous germ cell tumors due to lack of added diagnostic value over conventional imaging. Evidence indicates that PET/CT may not reliably differentiate viable tumor from necrosis or fibrosis in NSGCT, which can result in false-positive or false-negative findings. Therefore, it is reserved for select clinical scenarios, supporting a more targeted and judicious use of advanced imaging modalities (NCCN, 2025).

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Health Equity Considerations

Testicular, ovarian, and extragonadal germ cell tumors (GCTs) predominantly affect adolescents and young adults and are among the most curable solid malignancies; however, important inequities persist across socioeconomic, racial/ethnic, and health system factors. Population-based data demonstrate marked racial and ethnic differences in GCT incidence, stage at diagnosis, and survival, with rapidly rising incidence and disproportionately higher rates of advanced-stage disease among Hispanic, American Indian/Alaska Native, and non-Hispanic Black populations compared with non-Hispanic White patients (Almeida et al., 2025; Ghazarian & McGlynn, 2020). Socioeconomic hardship, insurance gaps, and geographic distance from specialty cancer centers are strongly associated with delayed diagnosis, later stage at presentation, treatment delays, and worse progression-free and overall survival, even after controlling for race and tumor characteristics (Karakus et al., 2026). These disparities are particularly consequential in GCTs, where early diagnosis can often obviate the need for intensive multimodality therapy and reduce long-term treatment-related morbidity.

Health equity considerations are further compounded in ovarian and extragonadal GCTs, which are rarer, less well studied, and more likely to be managed outside high-volume specialty centers. Compared with testicular GCTs, ovarian GCTs have lower survival and greater variability in care, reflecting limited evidence, lack of standardized risk stratification, and reduced access to subspecialty expertise—factors that disproportionately affect patients from underserved communities (Sköld et al., 2024). Extragonadal GCTs, including mediastinal and retroperitoneal primaries, also require complex multidisciplinary management that may be less accessible to patients with socioeconomic or geographic barriers. Imaging guidelines should therefore be applied with awareness of structural barriers to timely evaluation and surveillance, and efforts to standardize imaging pathways, reduce unnecessary delays, and facilitate referral to experienced centers are critical to mitigating inequities and improving outcomes across all GCT populations (Karakus et al., 2026; Sköld et al., 2024).

Oncology Imaging Guidelines

Testicular, Ovarian, and Extragonadal Germ Cell Tumors – Initial Work-Up/ Staging (ONC-20.1)

ON.TO.0020.1.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Suspicious testicular mass or ovarian mass with concern for metastatic disease on ultrasound • For all other ovarian masses prior to tissue diagnosis, see **Complex Adrenal Masses (PV-5.3)**	EITHER of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) or • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
After orchiectomy or oophorectomy in individuals with testicular, ovarian, and extragonadal germ cell tumors: • Orchiectomy/oophorectomy is both diagnostic and therapeutic, and imaging was not performed prior to surgery OR • Individual is Stage IS (i.e., has persistently elevated tumor markers)	EITHER of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) or • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Prior to initiation of chemotherapy to confirm staging, if prior imaging was performed ≥4 weeks ago in individuals with testicular, ovarian, and extragonadal germ cell tumors	Repeat abdominal imaging with ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) or • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)

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Indication	Medically Necessary Imaging Study
For ANY of the following in individuals with testicular, ovarian, and extragonadal germ cell tumors: • Testicular non-seminoma histology • Any ovarian germ cell tumor • Abdominal lymphadenopathy noted on CT scan • Abnormal chest x-ray or signs/ symptoms suggestive of chest involvement • Individual is Stage IS (i.e., has persistently elevated tumor markers)	In addition to the above abdominal/pelvic imaging: • CT Chest with contrast (CPT® 71260)
Individual is Stage IS (i.e., has persistently elevated tumor markers) in individuals with testicular, ovarian, and extragonadal germ cell tumors	In addition to the above, scrotal ultrasound (CPT® 76856 or CPT® 76857) to assess for a contralateral testis mass if one has not been conducted in the last 3 months
Prior surgery with incomplete staging for ovarian germ cell tumors	EITHER of the following: • CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) or • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Inconclusive conventional imaging for ovarian germ cell tumors	PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498)
Extragonadal Germ Cell Tumor	CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177)
Sex Cord Stromal Tumors	Once diagnosis confirmed, no imaging is considered medically necessary.

Background and Supporting Information

Germ cell tumors (GCTs) of the testis, ovary, and extragonadal sites are generally diagnosed through a combination of clinical examination, tumor markers, and imaging.

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Following diagnosis or strong suspicion of malignancy, an orchiectomy or oophorectomy is typically performed, which serves both diagnostic and therapeutic purposes. Postoperative tumor marker assessment, including AFP, β-hCG, and LDH, is essential for staging and risk stratification. Persistently elevated tumor markers after surgery define Stage IS disease and indicate likely residual or metastatic disease (NCCN, 2025; Stephenson et al., 2019).

Evidence Discussion

The recommended imaging strategy for initial work-up and staging of germ cell tumors is supported by evidence demonstrating that ultrasound is highly effective for initial evaluation of testicular masses. Ultrasound provides excellent spatial resolution, avoids radiation exposure, and is widely available, making it the preferred first-line modality. MRI does not improve diagnostic accuracy in this setting and may increase cost and delays, supporting its exclusion from routine initial evaluation (Stephenson et al., 2019).

Cross-sectional imaging with CT or MRI of the abdomen and pelvis is supported as the cornerstone for staging due to the high prevalence of retroperitoneal lymph node metastases. CT provides rapid image acquisition and excellent anatomic detail, which is critical in detecting nodal and visceral disease. MRI offers comparable diagnostic performance without ionizing radiation but is more susceptible to motion artifact and less widely available. These complementary strengths justify allowing either modality depending on clinical context while maintaining CT as the primary standard (Stephenson et al., 2019; NCCN, 2025).

Chest imaging is supported in individuals with higher-risk disease features, including non-seminomatous histology, abnormal abdominal imaging, or clinical suspicion of thoracic involvement. CT of the chest has higher sensitivity than chest radiography for detecting pulmonary metastases, particularly in non-seminomatous germ cell tumors, where skip metastases are more common. However, selective use of chest CT balances improved detection with concerns regarding radiation exposure (Stephenson et al., 2019).

The limited role of PET/CT in initial staging is supported by evidence demonstrating no significant improvement in clinical outcomes compared with conventional imaging. In non-seminomatous germ cell tumors, PET imaging has not shown sufficient accuracy in distinguishing viable tumor from necrosis and may lead to false-positive findings. Additionally, PET exposes patients to additional radiation and cost without clear benefit, supporting its restriction to select clinical scenarios (Stephenson et al., 2019).

Finally, repeat imaging prior to initiation of systemic therapy is supported by evidence indicating that germ cell tumors can have rapid growth kinetics. Updated imaging ensures accurate staging and appropriate treatment selection, reducing the risk of undertreatment or overtreatment based on outdated imaging findings (Stephenson et al., 2019).

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Testicular, Ovarian, and Extragonadal Germ Cell Tumors – Restaging/ Recurrence (ONC-20.2)

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v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Treatment response for individuals with testicular, ovarian, and extragonadal germ cell tumors with measurable disease or persistent elevated tumor markers, every 2 cycles	• CT Abdomen and Pelvis with contrast (CPT® 74177) OR • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) AND • CT with contrast of previously involved body areas
For any of the following in individuals with testicular, ovarian, and extragonadal germ cell tumors: • At end of adjuvant therapy ◦ Any stage embryonal tumor ◦ Any stage endodermal sinus tumor (i.e., yolk sac tumor) ◦ Stage II-IV dysgerminoma ◦ Stage I, Grade 2 or 3 immature teratoma ◦ Any grade, Stage II-IV immature teratoma ◦ Any stage non-gestational choriocarcinoma • During adjuvant therapy only for signs and symptoms of disease progression	CT Chest with contrast (CPT® 71260) AND EITHER of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) or • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Inconclusive conventional imaging in individuals with testicular, ovarian, and extragonadal germ cell tumors	PET/CT (CPT® 78815) or PET/MRI (CPT® 78813 and CPT® 76498)

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Indication	Medically Necessary Imaging Study
Seminoma with residual mass >3cm after completion of chemotherapy	• PET/CT (CPT® 78815) ◦ If PET/CT is positive, biopsy or resection should be considered ◦ If biopsy or resection is not performed, PET/CT may be repeated once in 6-12 weeks
Nonseminoma or pure seminoma with partial response or with residual mass and ALL of the following: • Abnormal AFP or beta-hCG levels • Need to evaluate for occult brain metastases	• MRI Brain without and with contrast (CPT® 70553)
Stage IIA pure seminoma or stage IIA nonseminoma with borderline retroperitoneal lymph nodes on preoperative imaging, 4-8 weeks after preoperative imaging	ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) or • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
End of therapy evaluation for NSGCT post chemotherapy or post retroperitoneal lymph node dissection (RPLND)	• CT Abdomen and Pelvis with contrast (CPT® 74177)
Recurrence suspected in individuals with testicular, ovarian, and extragonadal germ cell tumors, including increased tumor markers	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • Ultrasound (CPT® 76856 or CPT® 76857) of the remaining gonad if applicable
Unexplained pulmonary symptoms despite a negative chest x-ray, or new findings on chest x-ray in individuals with testicular, ovarian, and extragonadal germ cell tumors	• CT Chest with contrast (CPT® 71260)

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Indication	Medically Necessary Imaging Study
Sex cord stromal tumors with elevated inhibin or signs and symptoms of recurrence	• CT Chest with contrast (CPT® 71260) AND one of the following: ◦ CT Abdomen and Pelvis (CPT® 74177) OR ◦ MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197)

Background and Supporting Information

Following treatment of germ cell tumors (GCTs), restaging and evaluation for recurrence rely on a combination of imaging, tumor markers, and clinical assessment. Serum tumor markers, including alpha-fetoprotein (AFP), beta-human chorionic gonadotropin (β-hCG), and lactate dehydrogenase (LDH), remain integral for monitoring response to therapy and detecting recurrence, as changes in marker levels may precede radiographic findings (NCCN, 2025).

Patterns of residual disease and recurrence vary by histology. Seminomas often leave residual masses following chemotherapy that may represent fibrosis, necrosis, or viable tumor, whereas non-seminomatous germ cell tumors (NSGCTs) more frequently contain viable tumor or teratoma in residual masses. These differences influence the selection of imaging modalities and the need for additional diagnostic procedures such as biopsy or resection (NCCN, 2025).

Advanced or recurrent disease may also involve atypical metastatic sites, including the brain or contralateral gonad, particularly in the setting of abnormal tumor markers or high-risk histology. Imaging approaches are therefore tailored to clinical findings, tumor biology, and prior imaging results (NCCN, 2025).

Evidence Discussion

Imaging with CT or MRI during and after therapy is supported by evidence demonstrating that cross-sectional imaging provides accurate assessment of disease burden and treatment response in germ cell tumors. CT imaging offers high-resolution anatomic detail for evaluating retroperitoneal lymph nodes and visceral metastases, while MRI provides comparable diagnostic capability without ionizing radiation. The use of interval imaging during therapy helps identify treatment response or progression, allowing timely modification of therapy while balancing cumulative radiation exposure (NCCN, 2025).

PET/CT is selectively supported in the evaluation of residual masses in seminoma following chemotherapy, particularly for lesions greater than 3cm. Evidence indicates that PET/CT has value in distinguishing viable tumor from necrosis or fibrosis in these

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cases, which can guide decisions regarding biopsy, surgical resection, or observation. However, the potential for false-positive findings necessitates confirmatory evaluation or repeat imaging prior to intervention, supporting a cautious and targeted approach (NCCN, 2025).

In contrast, PET imaging is not routinely recommended for non-seminomatous germ cell tumors due to limited diagnostic accuracy in differentiating viable tumor from post-treatment changes. Instead, CT-based evaluation remains the standard for assessing residual disease in NSGCT. This avoids unnecessary additional radiation exposure and cost associated with PET imaging without a corresponding improvement in clinical outcomes (NCCN, 2025).

Comprehensive imaging for suspected recurrence, including CT of the chest, abdomen, and pelvis, is supported by evidence demonstrating common patterns of metastasis to retroperitoneal lymph nodes and lungs. Imaging of additional sites, such as the brain, is appropriate in the setting of abnormal tumor markers or clinical suspicion, as these findings may indicate advanced or disseminated disease. This risk-adapted imaging approach maximizes diagnostic accuracy while minimizing unnecessary imaging in low-risk scenarios (NCCN, 2025).

Oncology Imaging Guidelines

Testicular, Ovarian and Extragonadal Germ Cell Tumors – Surveillance (ONC-20.3)

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v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Stage I seminoma treated with orchiectomy alone (no radiotherapy or chemotherapy, also called active surveillance)	ONE of the following, every 4 months in year 1, then every 6 months for years 2 and 3, and then annually until year 5: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Stage I seminoma treated with radiotherapy and/or chemotherapy	ONE of the following, annually for 3 years: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)

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Indication	Medically Necessary Imaging Study
Stage IIA and non-bulky stage IIB seminomas treated with radiotherapy or chemotherapy	ONE of the following, once at 3 months, then once at 9-12 months after completion of therapy, then annually for 2 additional years: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Stage II seminoma treated with primary RPLND and NOT treated with adjuvant chemotherapy	ONE of the following, every 4 months in year 1, every 6 months in year 2, and annually in year 3: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Stage II seminoma treated with primary RPLND AND adjuvant chemotherapy	ONE of the following, at 6 months, 12 months, and 24 months: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)

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Indication	Medically Necessary Imaging Study
Bulky stage IIB, IIC, and III seminomas treated with chemotherapy	For individuals with ≤3cm residual mass, ONE of the following every 4 months for 1 year, every 6 months for 1 year, and then annually for 2 additional years: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) For individuals with >3cm residual mass and negative PET scan, ONE of the following at 6 and 12 months after completion of therapy, then annually until year 5: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) For individuals with thoracic disease: • CT Chest with contrast (CPT® 71260) every 2 months for 1 year, then every 3 months for 1 year, then annually until year 5 after completion of therapy

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Indication	Medically Necessary Imaging Study
Stage IA non-seminomatous germ cell tumors treated with orchiectomy alone (without risk factors)	ONE of the following, every 4 months for one year, every 6 months in the second year, and then annually for years 3, 4, and 5: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) • Scrotal ultrasound (CPT® 76856 or CPT® 76857) to assess for a contralateral testis mass if one has not been conducted in the last 3 months
Stage IB non-seminomatous germ cell tumors treated with orchiectomy alone (with risk factors – lymphovascular invasion or invasion into spermatic cord/scrotum)	ONE of the following, every 4 months for years 1 and 2, then every 6 months for year 3, and then once in year 4: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) • Scrotal ultrasound (CPT® 76856 or CPT® 76857) to assess for a contralateral testis mass if one has not been conducted in the last 3 months

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Indication	Medically Necessary Imaging Study
Stage IA/IB non-seminomatous germ cell tumors treated with chemotherapy and/or primary RPLND	ONE of the following, annually for 2 years: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) • Scrotal ultrasound (CPT® 76856 or CPT® 76857) to assess for a contralateral testis mass if one has not been conducted in the last 3 months
Stage II-III non-seminomatous germ cell tumors with complete response to chemotherapy +/- post-chemotherapy RPLND	ONE of the following, every 4 months in year 1, every 6 months in year 2, and then annually in year 3: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) For individuals with known thoracic disease or thoracic symptoms, every 4 months in year 1, every 6 months in year 2, then annually until year 4 after completion of therapy: • CT Chest with contrast (CPT® 71260)

Indication	Medically Necessary Imaging Study
Stage IIA, IIB, or IIC non-seminomatous germ cell tumors treated with post-primary RPLND AND adjuvant chemotherapy	ONE of the following, once at 3-4 months after completion of RPLND: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Stage IIA or IIB non-seminomatous germ cell tumors treated with post-primary RPLND WITHOUT adjuvant chemotherapy	ONE of the following, once at 4 months after completion of therapy and once in year 2: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) • MRI Abdomen without and with contrast (CPT® 74183) • MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
All ovarian germ cell tumors	• CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) every 3 months for 2 years, every 6 months for an additional year, and then after year 3, only for signs and symptoms of recurrence
• Sex cord stromal tumors (male and female) • Mature teratoma	• No routine advanced imaging is medically necessary for surveillance. • For symptoms, elevated biomarkers, or suspicious findings on physical exam, see **Testicular, Ovarian and Extragonadal Germ Cell Tumors - Restaging/Recurrence (ONC-20.2)** for suspected recurrence.
Extragonadal germ cell tumors	• CT of the involved region every 3 months for one year and every 6 months for one year

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Background and Supporting Information

Germ cell tumor (GCT) surveillance is essential due to the risk of recurrence following initial treatment, particularly within the first several years. These malignancies most commonly affect younger individuals and are associated with excellent long-term survival, making minimization of long-term harms from follow-up, particularly radiation exposure, an important consideration (NCCN, 2026; NCCN, 2025; Laukka et al., 2020).

Patterns of recurrence differ by histology. Seminomas most commonly recur in the retroperitoneum, whereas non-seminomatous germ cell tumors (NSGCTs) demonstrate more heterogeneous metastatic patterns, including pulmonary, nodal, and visceral disease. Thoracic involvement is particularly relevant in NSGCT and advanced disease, supporting selective chest imaging in surveillance (Meyer & Conces, 2002).

Surveillance protocols are risk-adapted based on stage, histology, and treatment modality. Imaging is typically combined with clinical evaluation and tumor markers to detect recurrence at an early and treatable stage while avoiding unnecessary imaging and associated harms (NCCN, 2026; NCCN, 2025; Rizzo et al., 2021).

Evidence Discussion

Surveillance imaging strategies in germ cell tumors are supported by the predictable patterns of recurrence, particularly in the retroperitoneum and lungs. CT of the abdomen and pelvis is considered the reference standard for detecting retroperitoneal nodal metastases due to its reproducibility and high spatial resolution. However, repeated CT imaging results in cumulative radiation exposure, which is a significant concern in this typically young population with long survival (NCCN, 2026; Laukka et al., 2020; Rizzo et al., 2021).

MRI is supported as an alternative to CT for abdominal and pelvic surveillance due to comparable diagnostic accuracy. Prospective evidence demonstrates that MRI with diffusion-weighted imaging has sensitivity equivalent to CT in detecting retroperitoneal metastases, including small lymph nodes. The primary benefit is elimination of ionizing radiation, although limitations include longer imaging time, susceptibility to motion artifact, and resource availability (Laukka et al., 2020).

Evidence supports a risk-adapted approach to surveillance intensity. In stage I seminoma, recurrence rates are relatively low, and studies indicate that most surveillance imaging does not identify relapse. For example, retrospective data show that fewer than 1% of surveillance CT scans identified recurrence, suggesting that many imaging studies may be unnecessary. These findings support structured imaging intervals and avoidance of excessive imaging to reduce cumulative radiation exposure, cost, and patient burden (Rizzo et al., 2021).

Chest imaging is supported in higher-risk populations and those with thoracic disease or symptoms. CT is more sensitive than chest radiography for detecting pulmonary

metastases and mediastinal lymphadenopathy, particularly in non-seminomatous tumors, where thoracic involvement may occur in up to 17%–25% of cases. However, isolated thoracic relapse is uncommon in early-stage disease, supporting selective rather than routine use of chest CT to balance improved detection with risks of radiation and false positives (Meyer & Conces, 2002).

Overall, surveillance imaging enables early detection of recurrence and contributes to high cure rates in germ cell tumors. However, its benefits must be balanced against harms, including radiation exposure, false-positive findings, cost, and psychological impact. Evidence supports the use of structured, stage- and risk-specific imaging protocols, favoring CT or MRI of the abdomen and pelvis with selective chest imaging, to optimize clinical outcomes while minimizing unnecessary imaging (NCCN, 2026; NCCN, 2025; Laukka et al., 2020; Rizzo et al., 2021; Meyer & Conces, 2002).

Oncology Imaging Guidelines

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v1.0.2027

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Ovarian Cancer (ONC-21)

Guideline Page

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Ovarian Cancer – General Considerations (ONC-21.0)

ON.OC.0021.0.A
v1.0.2027

Criteria

- Germ cell tumors and sex cord stromal tumors (granulosa cell tumors), are imaged according to **Testicular, Ovarian and Extragonadal Germ Cell Cancer (ONC-20)**.

Background and Supporting Information

Ovarian cancer encompasses a heterogeneous group of malignancies that arise from the ovary, fallopian tube, or peritoneum. These tumors are most commonly classified as epithelial ovarian cancers, primary peritoneal cancers, or fallopian tube cancers, which are managed similarly due to shared histologic and clinical features. Epithelial ovarian cancers represent the majority of cases and include several distinct histologic subtypes, including high-grade serous, endometrioid, clear cell, mucinous, and low-grade serous carcinomas (NCCN, 2026).

High-grade serous carcinoma is the most common subtype, accounting for approximately 70% of epithelial ovarian cancers, and is typically associated with aggressive clinical behavior and advanced stage at diagnosis. Other subtypes, such as endometrioid and clear cell carcinoma, have distinct molecular and clinical characteristics, while mucinous and low-grade serous carcinomas are less common and may demonstrate different patterns of spread and treatment response (NCCN, 2026).

Borderline tumors, also referred to as tumors of low malignant potential, represent a separate category characterized by atypical epithelial proliferation without stromal invasion. These tumors generally have a favorable prognosis but may recur, and when recurrence occurs, it may demonstrate features more consistent with invasive carcinoma. Primary peritoneal and fallopian tube cancers are closely related to epithelial ovarian cancers and are most often of serous histology, particularly high-grade serous carcinoma (NCCN, 2026).

Health Equity Considerations

Substantial health inequities persist across the ovarian cancer care continuum, including differences in stage at diagnosis, receipt of guideline-concordant treatment, access to genetic testing, and overall survival. Black women consistently experience worse survival compared with White women despite similar incidence rates, a disparity largely attributable to later-stage diagnosis, lower likelihood of receiving guideline-adherent care, and structural barriers rather than intrinsic tumor biology (Mei et al., 2023;

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Brubaker & Merritt, 2025). Socioeconomic status, insurance coverage, and geographic location further compound these inequities, with patients who are uninsured, publicly insured, or living in rural or low-resource areas less likely to be treated by gynecologic oncologists or at high-volume centers associated with improved outcomes (Mei et al., 2023). Importantly, when patients across racial and ethnic groups receive comparable, high-quality care, survival disparities are markedly reduced or eliminated, underscoring the central role of equitable access to evidence-based management (Mei et al., 2023; Brubaker & Merritt, 2025).

Inequities also extend to precision oncology and diagnostic evaluation, which directly intersect with imaging pathways. Black patients and those with non-private insurance are less likely to undergo germline and somatic testing for homologous recombination deficiency and other actionable biomarkers, limiting access to targeted therapies and appropriate surveillance strategies (Mei et al., 2023; Brubaker & Merritt, 2025). At a population level, ovarian cancer mortality has declined over time; however, improvements have been uneven, with persistent racial, regional, and urban–rural differences reflecting broader social determinants of health and variations in healthcare infrastructure and access (Razaq et al., 2025). Imaging guidelines should be applied with awareness of these disparities and support timely, guideline-concordant diagnostic evaluation regardless of race, socioeconomic status, or geography, as equitable implementation of imaging and downstream care remains a critical lever for reducing avoidable differences in ovarian cancer outcomes (Mei et al., 2023; Razaq et al., 2025).

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Screening for Ovarian Cancer (ONC-21.1)

ON.OC.0021.1.C
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Criteria

- The use of advanced imaging in ovarian cancer screening is not recommended by the USPSTF and is considered not medically necessary.

Background and Supporting Information

Ovarian cancer screening remains a clinical challenge due to the disease's relatively low prevalence but high mortality. The general population lifetime risk is approximately 1.1%–1.3%, yet ovarian cancer accounts for the majority of deaths among gynecologic malignancies, largely due to late-stage diagnosis (Expert Panel on GYN and OB Imaging, 2025; NCCN, 2026).

Early detection of ovarian cancer significantly improves outcomes, with 5-year survival rates exceeding 70%–90% for stage I–II disease but falling below 30% for advanced stages. However, most ovarian cancers are diagnosed at stage III or IV, which limits the effectiveness of treatment and underscores the importance of early detection strategies (Expert Panel on GYN and OB Imaging, 2025).

Evidence Discussion

The clinical stance that routine imaging is not medically necessary for ovarian cancer screening is supported by substantial evidence demonstrating lack of mortality benefit. Large randomized controlled trials evaluating screening with transvaginal ultrasound and CA-125 have consistently shown no significant reduction in ovarian cancer mortality despite increased detection of early-stage disease in some cohorts (Expert Panel on GYN and OB Imaging, 2025).

In addition to limited benefit, screening in average-risk populations is associated with meaningful harms. False-positive results are common and may lead to additional imaging, invasive procedures, and surgical interventions. For example, in the PLCO trial, a significant proportion of individuals with false-positive screening results underwent surgery, with a subset experiencing major complications. These findings support the conclusion that the risk-benefit ratio of imaging-based screening in average-risk populations is unfavorable (Expert Panel on GYN and OB Imaging, 2025).

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Ovarian Cancer – Suspected/Diagnosis (ONC-21.2)

ON.OC.0021.2.A
v1.0.2027

Criteria

- See: **Complex Adnexal Masses (PV-5.3)** for imaging guidelines for evaluation of suspected ovarian malignancies.
- To differentiate the origin of pelvic masses that are not clearly of ovarian origin, see: **Suspected Adnexal Mass (PV-5.1)**.
- Germ cell tumors and sex cord stromal tumors (granulosa cell tumors), are imaged according to **Testicular, Ovarian and Extragonadal Germ Cell Cancer (ONC-20)**.

Indication	Medically Necessary Imaging
• Pelvic signs or symptoms • Palpable pelvic mass	• Transvaginal (TV) ultrasound imaging (CPT® 76830) and/or Pelvic ultrasound (CPT® 76856 or CPT® 76857)
• Ultrasound shows complex and/or solid adnexal mass suspicious for ovarian malignancy or • Any suspicious signs/symptoms for ovarian malignancy (ascites, abdominal symptoms such as distension or tenderness, elevated CA-125, elevated LFTs, obstructive uropathy)	ANY of the following: • MRI Pelvis without and with contrast (CPT® 72197) ◦ MRI Pelvis without contrast (CPT® 72195) if contrast is contraindicated • CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ MRI Abdomen and MRI Pelvis without and with contrast (CPT® 74183 and CPT® 72197) are considered medically necessary in lieu of CT for individuals with renal insufficiency or contrast allergy. ◦ CT Abdomen and Pelvis without and with contrast (CT Urogram – CPT® 74178) only for symptoms of obstructive uropathy*

Background and Supporting Information

Evaluation of suspected ovarian malignancy typically begins with assessment of pelvic signs or symptoms and imaging of adnexal structures. The differentiation of benign from malignant adnexal masses is critical in clinical management. Many adnexal lesions are benign, and unnecessary surgical intervention should be avoided, while accurate

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identification of malignant lesions is necessary for timely referral and treatment. Imaging therefore plays a key role in risk stratification prior to surgical or oncologic intervention (Zhang et al., 2023).

Evidence Discussion

The use of transvaginal and pelvic ultrasound as the initial imaging modality for suspected ovarian malignancy is supported by evidence demonstrating its high sensitivity for detection of adnexal lesions and ability to guide risk stratification. Ultrasound is widely available, non-invasive, and provides real-time assessment of lesion morphology. However, variability in interpretation highlights the need for standardized systems such as O-RADS to improve diagnostic consistency and accuracy (Zhang et al., 2023).

Risk stratification systems such as O-RADS are supported by strong evidence demonstrating high sensitivity for malignancy detection. A meta-analysis of 26 studies including over 9,500 patients showed pooled sensitivity of approximately 95% for both O-RADS ultrasound and O-RADS MRI, supporting their use in identifying potentially malignant lesions. This high sensitivity minimizes the risk of missed cancers while allowing stratification of patients for appropriate management (Zhang et al., 2023).

Further imaging with MRI or CT is supported when ultrasound findings are suspicious or indeterminate. MRI offers improved soft-tissue contrast and higher specificity (approximately 90%) compared with ultrasound, making it particularly valuable for characterizing indeterminate lesions and refining preoperative risk assessment. CT, while less specific for lesion characterization, provides important information regarding disease extent, including ascites, lymphadenopathy, and other signs of advanced malignancy (Zhang et al., 2023; NCCN, 2025).

This stepwise imaging approach balances diagnostic accuracy with potential harms. Ultrasound serves as an effective initial screening tool, while additional imaging is reserved for higher-risk or indeterminate cases to avoid unnecessary procedures. This strategy reduces the likelihood of overtreatment of benign lesions while ensuring timely identification and management of malignancy, supporting improved clinical outcomes through appropriate triage and staging (Zhang et al., 2023).

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Ovarian Cancer – Initial Work-Up/Staging (ONC-21.3)

ON.OC.0021.3.A
v1.0.2027

Criteria

- Germ cell tumors and sex cord stromal tumors (granulosa cell tumors), are imaged according to Testicular, Ovarian and Extragonadal Germ Cell Cancer (ONC-20).

Indication	Medically Necessary Imaging Study
Initial staging of all newly diagnosed ovarian cancer, if imaging has not yet been performed	• CT Abdomen and Pelvis with contrast (CPT® 74177) OR MRI Abdomen and MRI Pelvis without and with contrast (CPT® 74183 and CPT® 72197) • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) for biopsy-proven disease or chest symptoms or abnormal chest x-ray prior to biopsy
ANY of the following in individuals with ovarian cancer: • Primary peritoneal disease with biopsy-proven malignancy consistent with ovarian carcinoma • Elevated tumor markers with negative or inconclusive CT or MRI imaging	ONE of the following: • MRI Abdomen without and with contrast (CPT® 74183) and/or MRI Pelvis without and with contrast (CPT® 72197) if not yet performed OR • PET/CT (CPT® 78815)
If both CT and MRI are inconclusive in individuals with ovarian cancer	• PET/CT (CPT® 78815) OR • PET/MRI (CPT® 78813 and 76498)
If PET/CT is inconclusive in individuals with ovarian cancer	• PET/MRI (CPT® 78813 and 76498)

Background and Supporting Information

Initial work-up and staging of ovarian cancer are essential to define disease extent, guide treatment planning, and determine resectability. Ovarian cancer commonly presents with advanced intraperitoneal dissemination, involving the omentum, peritoneal

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surfaces, and regional lymph nodes. Accurate baseline imaging is therefore necessary to assess both local and distant disease burden (NCCN, 2026).

Evidence Discussion

The use of CT of the abdomen and pelvis with contrast as the primary modality for initial staging is supported by its ability to comprehensively evaluate disease extent in ovarian cancer. Evidence demonstrates that CT provides accurate assessment of peritoneal carcinomatosis, omental disease, and nodal involvement, all of which are critical for staging and surgical planning. Advanced imaging improves identification of metastatic disease and assists in determining operability and treatment approach (NCCN, 2026).

MRI is supported as an appropriate alternative in individuals who cannot undergo contrast-enhanced CT, such as those with renal insufficiency or contrast allergy. MRI provides superior soft tissue resolution and has been shown to have comparable accuracy to CT for staging and assessing peritoneal tumor burden. This allows adequate characterization of disease distribution while avoiding the limitations of non-contrast CT imaging (NCCN, 2026).

Chest imaging with CT is supported in the setting of biopsy-proven disease, abnormal chest imaging, or symptoms suggestive of thoracic involvement. Evidence demonstrates that CT is effective for detecting pleural effusions and pulmonary metastases, which influence staging and treatment planning. Selective use of chest CT balances improved detection with considerations of radiation exposure and clinical necessity (NCCN, 2026).

PET/CT is supported as a problem-solving tool when CT or MRI findings are inconclusive or discordant. Evidence indicates that PET/CT has high accuracy for detecting metabolically active metastatic disease, improving diagnostic confidence in cases of indeterminate lesions. However, due to cost and potential false positives, its use is best reserved for selected scenarios rather than routine initial staging (NCCN, 2026).

Oncology Imaging Guidelines

Ovarian Cancer – Restaging/Recurrence (ONC-21.4)

ON.OC.0021.4.A
v1.0.2027

Criteria

- Germ cell tumors and sex cord stromal tumors (granulosa cell tumors), are imaged according to Testicular, Ovarian and Extragonadal Germ Cell Cancer (ONC-20).

Indication	Medically Necessary Imaging Study
Individuals with ovarian cancer with completely resected or definitively treated with chemotherapy and normal(ized) tumor markers	• No advanced imaging is considered medically necessary
ANY of the following in individuals with ovarian cancer: • Unresected disease • Unknown preoperative markers • Difficult or abnormal examination • Elevated LFTs • Elevated tumor markers • Signs or symptoms of recurrence	• CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ MRI Abdomen and MRI Pelvis without and with contrast (CPT® 74183 and CPT® 72197) in lieu of CT for individuals with renal insufficiency or contrast allergy. • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) for ANY of the following: ◦ Known prior thoracic disease ◦ New or worsening pulmonary symptoms ◦ New or worsening chest x-ray findings ◦ Rising tumor markers

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Indication	Medically Necessary Imaging Study
Monitoring response to neoadjuvant treatment (every 2 cycles, or ~every 6 to 8 weeks) in individuals with ovarian cancer	• CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ MRI Abdomen and MRI Pelvis without and with contrast (CPT® 74183 and CPT® 72197) in lieu of CT for individuals with renal insufficiency or contrast allergy. • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) for ANY of the following: ◦ Known prior thoracic disease ◦ New or worsening pulmonary symptoms ◦ New or worsening chest x-ray findings
In in individuals with ovarian cancer: • CT negative or inconclusive and CA-125 continues to rise or elevated LFTs • Conventional imaging failed to demonstrate tumor or if persistent radiographic mass with rising tumor markers	ONE of the following: • MRI Abdomen and MRI Pelvis without and with contrast (CPT® 74183 and CPT® 72197) OR • PET/CT (CPT® 78815)
If both CT and MRI are inconclusive in individuals with ovarian cancer	• PET/CT (CPT® 78815)
If CT, MRI, and PET/CT are inconclusive in individuals with ovarian cancer	• PET/MRI (CPT® 78813 and 76498)

Background and Supporting Information

Restaging and evaluation for recurrence in ovarian cancer rely on clinical assessment, tumor markers, and imaging. Recurrence is common, particularly in advanced-stage epithelial ovarian cancer, and may involve the peritoneum, lymph nodes, liver, and lungs. Serum tumor markers such as CA-125 are frequently used to detect recurrence, often preceding radiographic findings (NCCN, 2026).

Evidence Discussion

The recommendation to avoid routine advanced imaging in individuals with completely resected disease and normalized tumor markers is supported by evidence showing low yield of imaging in the absence of clinical or biochemical suspicion. Tumor markers such as CA-125 are sensitive for detecting recurrence, and routine imaging in asymptomatic individuals can lead to unnecessary radiation exposure, false-positive findings, and additional interventions without improving outcomes (NCCN, 2026).

When recurrence is suspected based on symptoms, abnormal examination, or rising tumor markers, CT of the abdomen and pelvis with contrast is supported as the primary imaging modality. CT provides comprehensive evaluation of common sites of recurrence, including peritoneal surfaces and visceral organs, and is essential for assessing disease burden and guiding treatment planning. Serial CT imaging during therapy also allows for objective assessment of response to treatment (NCCN, 2026).

MRI is supported as an alternative to CT in individuals with contraindications to contrast or when CT findings are inconclusive. Evidence demonstrates that MRI provides equivalent accuracy for staging and assessment of peritoneal disease, with superior soft tissue contrast that can improve lesion characterization. This makes MRI a valuable adjunct in cases where CT does not adequately explain clinical or laboratory findings (NCCN, 2026).

Chest CT is recommended selectively in patients with known thoracic disease, new pulmonary symptoms, abnormal chest radiographs, or rising tumor markers. Evidence supports its use for detecting pulmonary metastases and pleural effusions, which are important for staging and treatment planning. Selective use balances diagnostic benefit with radiation exposure (NCCN, 2026).

PET/CT is supported for evaluation of indeterminate lesions or discordant clinical scenarios, such as rising CA-125 with negative or inconclusive CT imaging. Evidence indicates that PET/CT has high sensitivity for metabolically active disease and can identify otherwise occult metastases. However, due to cost and potential for false positives, its use is best reserved for problem-solving scenarios. PET/MRI may be considered when all other imaging modalities remain inconclusive, providing combined anatomic and metabolic information (NCCN, 2026).

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Ovarian Cancer – Surveillance (ONC-21.5)

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Criteria

- Germ cell tumors and sex cord stromal tumors (granulosa cell tumors), are imaged according to Testicular, Ovarian and Extragonadal Germ Cell Cancer (ONC-20).

Indication	Medically Necessary Imaging Study
Stages I-III ovarian cancer	• Advanced imaging is not considered medically necessary for surveillance
Measurable metastatic disease on maintenance therapy or being monitored off therapy in individuals with ovarian cancer	Every 3 months for up to 5 years after completion of active treatment: • CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ MRI Abdomen and MRI Pelvis without and with contrast (CPT® 74183 and CPT® 72197) in lieu of CT for individuals with renal insufficiency. • CT with contrast of previously involved body areas • CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) for known history of chest involvement

Background and Supporting Information

Surveillance following treatment of ovarian cancer is focused on detection of recurrence while minimizing unnecessary interventions. The majority of recurrences occur within the first several years after treatment, and monitoring typically includes clinical evaluation and tumor marker assessment, particularly CA-125. Imaging is used selectively based on disease status and clinical findings (NCCN, 2026).

Evidence Discussion

The recommendation that advanced imaging is not medically necessary for surveillance in individuals with stage I–III ovarian cancer and no evidence of disease is supported by evidence demonstrating limited benefit of routine imaging in asymptomatic patients. Surveillance based on clinical evaluation and tumor markers, particularly CA-125, is sufficient for detecting recurrence in many cases. Routine imaging in this setting

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may lead to unnecessary radiation exposure, false-positive findings, and additional interventions without improving clinical outcomes (NCCN, 2026).

In contrast, imaging is supported in individuals with measurable metastatic disease or those undergoing maintenance therapy. Serial CT imaging every 3 months allows for objective assessment of disease burden and monitoring of treatment response. This approach is consistent with the biology of advanced ovarian cancer, where disease progression or response to therapy must be evaluated at defined intervals to guide management decisions (NCCN, 2026).

CT of the abdomen and pelvis with contrast is supported as the primary modality for surveillance in patients with active or measurable disease due to its reliability in detecting peritoneal and visceral metastases. MRI serves as an appropriate alternative for individuals with renal insufficiency or contraindications to contrast, providing comparable soft tissue characterization necessary for accurate assessment. This ensures that diagnostic quality is maintained while minimizing risks associated with contrast exposure (NCCN, 2026).

Additional imaging of previously involved body regions, including the chest, is supported when there is known prior involvement or clinical suspicion. Selective chest CT enables detection of pulmonary metastases or pleural effusions that may influence treatment decisions. This targeted approach avoids unnecessary imaging while ensuring clinically significant disease is identified (NCCN, 2026).

Overall, the surveillance strategy reflects a risk-adapted approach that limits imaging in low-risk, asymptomatic individuals while employing regular imaging in those with active disease. This balances the benefits of early detection and treatment monitoring with the potential harms of over-imaging, including radiation exposure, cost, and false-positive findings (NCCN, 2026).

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Uterine Cancer (ONC-22)

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Uterine Cancer – General Considerations (ONC-22.0)

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Criteria

- Gestational trophoblastic neoplasia (GTN) – see: **Molar Pregnancy and Gestational Trophoblastic Neoplasia (GTN) (PV-16.1)** in the Pelvic Imaging Guidelines.
- Imaging is not routinely considered medically necessary pre-operatively for laparoscopic/minimally invasive surgery unless initial staging criteria are met. Pelvic and para-aortic lymphadenectomy can still be performed.

Background and Supporting Information

Uterine cancers include a spectrum of malignancies arising from the endometrium and uterine mesenchyme. The most common histologic subtype is endometrial carcinoma, which is typically adenocarcinoma, while uterine sarcomas represent a less common but biologically distinct group of mesenchymal tumors. These entities are managed within the same general diagnostic and staging framework due to overlapping anatomic involvement and clinical presentation (NCCN, 2026).

Health Equity Considerations

Marked and persistent disparities exist across the uterine cancer care continuum, with Black women experiencing the highest incidence and mortality and the poorest survival outcomes compared with all other racial and ethnic groups. Uterine cancer mortality among Black women is approximately twofold higher than among White women, and 5-year survival remains substantially lower, even after accounting for stage, histology, comorbidities, and treatment factors, underscoring that these inequities are not biologically driven but socially mediated (Somasegar et al., 2023; Whetstone et al., 2022). Black women are more likely to present with advanced-stage disease and aggressive nonendometrioid histologies and are less likely to receive guideline-concordant diagnostic evaluation and timely surgical management (Grubbs et al., 2023; Seay et al., 2024; Whetstone et al., 2022). Hispanic women generally have lower incidence and similar or slightly better overall survival compared with White women, despite rising incidence trends and higher likelihood of later-stage diagnosis, a pattern often described as the "Hispanic paradox" (Rodriguez et al., 2021; Whetstone et al., 2022). Asian women overall demonstrate similar or improved survival compared with White women, though outcomes vary by geography, neighborhood socioeconomic status, and migration status, highlighting the importance of disaggregated data (Meade et al., 2025; Whetstone et al., 2022).

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Structural and socioeconomic inequities are major drivers of observed disparities in uterine cancer outcomes. Black, Hispanic, and American Indian or Alaska Native women are consistently less likely to receive guideline-adherent treatment, including definitive surgery, minimally invasive approaches, lymph node assessment, and chemotherapy, with lower neighborhood socioeconomic status further compounding these gaps across racial and ethnic groups (Rodriguez et al., 2021; Grubbs et al., 2023; Whetstone et al., 2022). Geographic variation further influences survival, with race-based disparities persisting across both high- and low-diversity regions and even among patients with early-stage, highly treatable disease, suggesting systemic barriers rather than differences in tumor biology or care-seeking behavior alone (Meade et al., 2025). Importantly, disparities persist despite Black women often receiving care at high-volume or academic centers, indicating that access alone is insufficient without equitable delivery of evidence-based imaging, diagnosis, and treatment (Whetstone et al., 2022). Health equity in uterine cancer care requires consistent application of guideline-concordant imaging and management, attention to social determinants of health, and deliberate efforts to mitigate the effects of structural racism and socioeconomic disadvantage on diagnostic timeliness and treatment quality (Somasegar et al., 2023; Whetstone et al., 2022).

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Uterine Cancer – Suspected/Diagnosis (ONC-22.1)

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- See: **Abnormal Uterine Bleeding (PV-2.1)** in the Pelvic Imaging Guidelines for evaluation of suspected uterine malignancies.

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Uterine Cancer – Initial Work-Up/Staging (ONC-22.2)

ON.UC.0022.2.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
ANY of the following in individuals with uterine cancer: • Extra-uterine disease suspected • To assess local extent of tumor prior to fertility-sparing surgery for well-differentiated Stage IA (grade 1) uterine cancer • Poor surgical candidate (due to medical comorbidities) considering medical therapy	• MRI Pelvis without and with contrast (CPT® 72197) • Transvaginal ultrasound (CPT® 76830) if MRI is contraindicated • Chest x-ray ◦ CT Chest with contrast (CPT® 71260) for: ▪ New or worsening pulmonary symptoms ▪ New or worsening chest x-ray findings In addition, for surgical staging: • Lymph system imaging (lymphoscintigraphy, CPT® 78195) ◦ SPECT/CT (CPT® 78830) if requested
ANY of the following in individuals with uterine cancer: • Abdominal symptoms or abnormal examination findings • Elevated LFTs • Other imaging studies suggest liver involvement	ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160)

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Indication	Medically Necessary Imaging Study
ANY of the following high-risk histologies in individuals with uterine cancer: • Papillary serous • Clear cell • High-grade/poorly differentiated endometrioid carcinoma • Uterine sarcomas: ◦ Carcinosarcoma ◦ Soft tissue sarcoma of the uterus ◦ Leiomyosarcoma ◦ Rhabdomyosarcoma ◦ Undifferentiated sarcoma ◦ Endometrial stromal sarcoma	• CT Chest (CPT® 71260) with contrast and CT Abdomen and Pelvis (CPT® 74177) with contrast • Lymph system imaging (lymphoscintigraphy, CPT® 78195) ◦ SPECT/CT (CPT® 78830) if requested
Individuals with uterine cancer with tumors detected incidentally or incompletely staged surgically ***and*** ANY of the following high-risk features: • Myoinvasion greater than 50% • Cervical stromal involvement • Lymphovascular invasion • Tumor greater than 2cm	• CT Chest (CPT® 71260) with contrast and CT Abdomen and Pelvis (CPT® 74177) with contrast
Inconclusive findings on conventional imaging in individuals with uterine cancer	• PET/CT scan (CPT® 78815)

Evidence Discussion

The clinical criteria supporting selective imaging in the initial work-up of uterine cancer are based on evidence that imaging complements, but does not replace, surgical staging. Surgical staging remains the diagnostic gold standard due to its ability to accurately assess depth of invasion and nodal involvement, while imaging primarily assists with preoperative planning and risk stratification. Imaging findings can help identify patients with higher likelihood of extrauterine disease or advanced-stage cancer; however, limitations in detecting microscopic metastases prevent imaging from supplanting surgical staging (Expert Panel on GYN and OB Imaging, 2020; Sbarra et al., 2023; NCCN, 2026).

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MRI of the pelvis without and with contrast is supported as the preferred modality for evaluating local tumor extent when clinically indicated, such as suspected extrauterine disease or assessment prior to fertility-sparing treatment. Evidence demonstrates that MRI provides the highest accuracy for evaluating myometrial invasion and cervical stromal involvement due to its superior soft tissue contrast. Meta-analyses and comparative studies show that contrast-enhanced MRI outperforms ultrasound and CT in assessing tumor depth and local spread, which are critical prognostic factors influencing treatment decisions (Expert Panel on GYN and OB Imaging, 2020; Sbarra et al., 2023).

Transvaginal ultrasound is an appropriate alternative when MRI is contraindicated, with moderate diagnostic accuracy for evaluating myometrial invasion. However, evidence shows that ultrasound is more limited by technical factors, including body habitus, tumor size, and coexisting uterine pathology, and therefore has lower overall accuracy compared with MRI. Its inclusion as an alternative reflects a balance between accessibility and diagnostic performance while maintaining adequate evaluation in patients unable to undergo MRI (Expert Panel on GYN and OB Imaging, 2020; Sbarra et al., 2023).

The criteria recommending chest imaging with escalation to CT for abnormal findings or symptoms reflect evidence that pulmonary metastases are uncommon in low-risk disease and imaging should be symptom-directed. Similarly, CT of the chest, abdomen, and pelvis is supported in patients with suspected metastatic disease, high-risk histologies (e.g., serous, clear cell, carcinosarcoma), or abnormal clinical findings. CT demonstrates utility for detection of nodal and distant metastases, although sensitivity for nodal disease is limited, reinforcing its use in higher-risk populations rather than routine staging of low-risk disease (Expert Panel on GYN and OB Imaging, 2020; Sbarra et al., 2023; NCCN, 2026).

PET/CT is reserved for cases with suspected metastases when conventional imaging is inconclusive. Evidence shows high specificity (~94%) but moderate sensitivity (~72%) for detecting lymph node metastases, supporting its role as a problem-solving tool rather than a first-line modality. The selective use of PET/CT minimizes unnecessary radiation and cost while maintaining diagnostic accuracy in complex or indeterminate cases (Expert Panel on GYN and OB Imaging, 2020; Sbarra et al., 2023).

Lymphatic imaging for surgical staging (e.g., lymphoscintigraphy with or without SPECT/CT) is supported by evidence demonstrating that sentinel lymph node mapping improves detection of nodal metastases with low false-negative rates and reduces morbidity compared with full lymphadenectomy. This approach enhances staging accuracy while limiting complications such as lymphedema, aligning with the criteria supporting targeted lymphatic imaging in appropriate surgical candidates (Expert Panel on GYN and OB Imaging, 2020; NCCN, 2026).

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Uterine Cancer – Restaging/Recurrence (ONC-22.3)

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v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Individuals with uterine cancer with: • Unresected disease • Medically inoperable disease • Incomplete surgical staging • Difficult or abnormal examination • Elevated LFTs or rising tumor markers • Signs or symptoms of recurrence	• CT Chest with contrast (CPT® 71260) **and** • CT Abdomen and Pelvis with contrast (CPT® 74177)
Monitoring response to chemotherapy (every 2 cycles, ~every 6-8 weeks) for individuals with uterine cancer with: • Unresected primary disease • Metastatic disease	• CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Chest with contrast (CPT® 71260) for: ◦ Known prior thoracic disease ◦ New or worsening pulmonary symptoms ◦ New or worsening chest x-ray findings
Any of the following in individuals with uterine cancer: • After fertility sparing treatment • Inconclusive CT scan findings	• MRI Pelvis without and with contrast (CPT® 72197)
• Inconclusive findings on conventional imaging in individuals with uterine cancer	• PET/CT (CPT® 78815)

Background and Supporting Information

Restaging and evaluation for recurrence in uterine cancer are guided by clinical findings, tumor biology, and prior treatment. Most patients with endometrial cancer are diagnosed at an early stage and treated surgically, with relatively favorable outcomes; however, recurrence risk varies based on tumor grade, stage, and histology. Recurrences most

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commonly occur in the pelvis, particularly at the vaginal cuff, but can also involve lymph nodes, peritoneum, liver, and lungs (Reinhold et al., 2020; Salani et al., 2017).

Detection of recurrence relies primarily on clinical assessment, including patient-reported symptoms and physical examination. Imaging is generally reserved for cases in which recurrence is suspected based on abnormal clinical findings, rising tumor markers, or incomplete prior staging. Because most recurrences occur within the first 3 years after treatment, clinical vigilance during this time is critical (Salani et al., 2017).

Evidence Discussion

Evidence strongly supports limiting imaging to individuals with suspected recurrence rather than routine use in asymptomatic patients. Studies demonstrate that most recurrences are detected through symptoms and physical examination, with detection rates exceeding 80% when both are used together. Routine imaging in asymptomatic individuals has low diagnostic yield and does not improve survival outcomes, while increasing cost, radiation exposure, and risk of false-positive findings, supporting a symptom-driven imaging approach (Salani et al., 2017).

CT of the chest, abdomen, and pelvis is supported as the primary imaging modality for evaluation of suspected recurrence or incomplete staging. Evidence shows that CT has substantially higher detection rates in symptomatic individuals (up to ~46%) compared with asymptomatic populations (~4%), reinforcing its appropriate use when clinical suspicion exists. CT also allows comprehensive evaluation of common metastatic sites, including lungs, liver, lymph nodes, and peritoneum, which is essential for treatment planning (Salani et al., 2017; Expert Panel on GYN and OB Imaging, 2020).

MRI of the pelvis is supported in specific clinical scenarios, including evaluation after fertility-sparing treatment or when CT findings are inconclusive. Evidence demonstrates that MRI provides superior soft tissue contrast and allows accurate assessment of local tumor extent, including myometrial invasion and nodal or adnexal involvement. This is particularly important in patients undergoing conservative management, where accurate assessment of residual or recurrent disease directly impacts treatment decisions (Expert Panel on GYN and OB Imaging, 2020; NCCN, 2026).

PET/CT is supported as a problem-solving modality when conventional imaging is inconclusive. Meta-analyses demonstrate high specificity (~94%) and moderate sensitivity (~72%) for detection of metastatic disease, indicating its value in confirming or excluding recurrence in indeterminate cases. However, due to cost, radiation exposure, and limited incremental benefit in routine use, PET/CT is reserved for select scenarios where additional diagnostic clarity is required (Expert Panel on GYN and OB Imaging, 2020; Salani et al., 2017).

For monitoring response to systemic therapy, interval CT imaging is supported because it provides reproducible and objective assessment of tumor burden over time.

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Performing imaging approximately every 2 treatment cycles allows timely identification of progression or response, facilitating appropriate adjustment of therapy. This approach balances the benefit of close disease monitoring with the risks associated with repeated imaging, supporting structured and clinically indicated surveillance (NCCN, 2026).

Oncology Imaging Guidelines

Uterine Cancer – Surveillance (ONC-22.4)

ON.UC.0022.4.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Stage I-III of uterine carcinoma	Advanced imaging is not routinely considered medically necessary
Measurable metastatic uterine cancer on maintenance therapy or being monitored off therapy	Every 3 months for up to 5 years after completion of definitive treatment: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved body areas
All stages of uterine sarcoma: • Soft tissue sarcoma of the uterus • Leiomyosarcoma • Adenosarcoma • Carcinosarcoma • Rhabdomyosarcoma • Undifferentiated sarcoma • Endometrial stromal sarcoma	CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) every 3 months for 3 years, then every 6 months for 2 years, and then every 1-2 years until year 10

Background and Supporting Information

Surveillance in uterine cancer is guided by risk of recurrence, disease stage, histology, and prior treatment. Most patients with endometrial carcinoma present with early-stage disease and have favorable outcomes, with recurrence rates ranging from approximately 2% to 15% in early-stage disease and higher in advanced-stage or high-risk histologies. The majority of recurrences occur within the first 3 years following treatment (Salani et al., 2017; NCCN, 2026).

Patterns of recurrence typically involve the pelvis, vaginal cuff, lymph nodes, peritoneum, and lungs. Surveillance strategies vary by disease type, with uterine sarcomas demonstrating higher recurrence rates and a propensity for distant spread,

Oncology Imaging Guidelines

including pulmonary and hepatic metastases. These differences in tumor biology inform imaging intensity and duration (Salani et al., 2017; NCCN, 2026).

Evidence Discussion

The recommendation that advanced imaging is not routinely medically necessary for surveillance in stage I–III uterine carcinoma is supported by evidence demonstrating low yield of imaging in asymptomatic individuals. Studies show that the majority of recurrences are detected through symptoms and physical examination, with detection rates exceeding 80% when combined. Routine imaging has not demonstrated improvement in survival outcomes and introduces potential harms, including radiation exposure, false-positive findings, and increased healthcare costs (Salani et al., 2017).

In contrast, imaging plays an important role in patients with measurable metastatic disease or those undergoing maintenance therapy. Serial CT imaging every 3 months allows objective assessment of tumor burden and treatment response, facilitating timely modification of therapy. This approach is supported by evidence demonstrating the need for consistent and reproducible imaging to monitor progression in advanced disease, where clinical examination alone is insufficient (NCCN, 2026).

For uterine sarcomas, the recommendation for more intensive surveillance with CT of the chest, abdomen, and pelvis is supported by their higher recurrence rates and tendency for distant metastasis, particularly to the lungs and liver. Evidence shows that these tumors have recurrence rates exceeding 50% in some subtypes and often recur at distant sites; therefore, periodic imaging is necessary to detect potentially treatable disease and guide management over an extended follow-up period (Salani et al., 2017; NCCN, 2026).

Oncology Imaging Guidelines

Gestational Trophoblastic Neoplasia (GTN) (ONC-22.5)

ON.UC.0022.5.A
v1.0.2027

Criteria

- The most common form of gestational trophoblastic disease (GTD) is hydatidiform mole (HM), a benign form, also known as molar pregnancy.
  - See: **Molar Pregnancy and GTN (PV-16.1)**
- Surveillance is generally with serial monitoring of hCG levels, and advanced imaging is reserved for high-risk histologies where hCG levels may not be a reliable marker.

Indication	Medically Necessary Imaging Study
Initial staging in individuals with GTN	• CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
EITHER of the following in individuals with GTN: • Pulmonary metastases noted on CT scan • Signs/symptoms of CNS involvement	• MRI Brain without and with contrast (CPT® 70553)
EITHER of the following in individuals with GTN: • Monitoring response to systemic therapy (every 2 cycles, i.e., 6-8 weeks) • Suspected progression	• CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
Surveillance for any of the following high risk histologies in individuals with GTN: • Placental site trophoblastic tumor (PSTT) • Epithelioid trophoblastic tumor (ETT)	Annually for 2 years: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)

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Background and Supporting Information

Gestational trophoblastic disease (GTD) comprises a spectrum of placental-derived disorders ranging from benign hydatidiform mole (HM) to malignant gestational trophoblastic neoplasia (GTN). GTN includes invasive mole, choriocarcinoma, placental site trophoblastic tumor (PSTT), and epithelioid trophoblastic tumor (ETT), which can metastasize to distant organs such as the lungs, brain, liver, and other sites. Despite metastatic potential, these tumors are highly curable, with treatment often preserving fertility (NCCN, 2026).

Serum human chorionic gonadotropin (hCG) plays a central role in diagnosis, staging, and surveillance of GTN. Most forms of GTN, particularly post-molar disease and choriocarcinoma, produce hCG, allowing for sensitive monitoring of disease activity and treatment response. In contrast, intermediate trophoblastic tumors (PSTT and ETT) produce lower levels of hCG, making imaging more important in their surveillance (NCCN, 2026).

Evidence Discussion

The use of CT chest, abdomen, and pelvis for initial staging of GTN is supported by its ability to detect metastatic disease, particularly in the lungs, which are the most common site of spread. NCCN guidelines recommend comprehensive imaging at diagnosis to determine disease extent and calculate FIGO stage and prognostic score, which directly influence treatment intensity. This approach ensures accurate risk stratification while balancing the need for timely initiation of therapy in a highly curable disease (NCCN, 2026).

Brain MRI is supported in patients with pulmonary metastases or neurologic symptoms due to the risk of central nervous system involvement, particularly in choriocarcinoma, where approximately 20% of patients may develop brain metastases. Early detection of CNS disease is critical because these lesions may require treatment modification and can be associated with significant morbidity if not promptly identified. Selective use of brain imaging therefore maximizes diagnostic yield while avoiding unnecessary imaging in low-risk patients (NCCN, 2026).

For monitoring response to therapy and evaluating suspected progression, repeat CT imaging of the chest, abdomen, and pelvis is supported to assess interval changes in metastatic disease. Although hCG is the primary marker for response assessment, imaging provides complementary anatomic information, particularly in cases of discordant clinical findings or when evaluating residual disease. This combined approach ensures accurate assessment of treatment efficacy and guides ongoing management (NCCN, 2026).

Routine post-treatment imaging is not recommended for most patients with GTN once hCG normalizes because evidence demonstrates that hCG is a highly sensitive marker

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for recurrence. Limiting imaging in this population reduces radiation exposure, cost, and false-positive findings without compromising detection of recurrence. However, for PSTT and ETT, where hCG is less reliable, surveillance imaging is indicated. These tumors may recur without significant hCG elevation, and periodic CT imaging improves detection of recurrence in this subgroup (NCCN, 2026).

Oncology Imaging Guidelines

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Cervical Cancer (ONC-23)

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Cervical Cancer – General Considerations (ONC-23.0)

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Criteria

- Primary histology for cervical cancer is squamous cell. Other, less common histologies are adenosquamous and adenocarcinoma. If biopsy is consistent with one of these less common histologies, it is necessary to clarify that tumor is not of primary uterine origin.
- If the primary histology is uterine in origin, follow imaging recommendations for uterine cancer, see: **Uterine Cancer (ONC-22)**.

Background and Supporting Information

Cervical cancer is a malignancy arising from the cervix, most commonly associated with human papillomavirus (HPV) infection. Histologically, cervical cancers are predominantly squamous cell carcinomas, accounting for approximately 80–90% of cases worldwide, while adenocarcinoma and adenosquamous carcinoma represent less common subtypes. These tumors arise from epithelial cells and demonstrate stromal invasion and variable patterns of growth (NCCN, 2026).

Less common histologies, including adenocarcinoma and adenosquamous carcinoma, may share overlapping morphologic and immunohistochemical features with uterine cancers, particularly endometrial carcinomas. Accurate determination of the primary site is therefore essential, as treatment strategies and staging differ significantly between cervical and uterine malignancies. Pathologic evaluation, including morphology, HPV testing, and immunohistochemical markers, plays a key role in distinguishing primary cervical tumors from tumors of uterine origin (NCCN, 2026).

HPV status is an important biological and prognostic factor in cervical cancer. Most cervical cancers are HPV-associated, particularly squamous cell carcinomas and many adenocarcinomas, while HPV-independent tumors tend to present at a more advanced stage and may have different molecular characteristics and clinical behavior. Determination of HPV status is recommended to support accurate histologic classification and guide clinical management (NCCN, 2026).

Health Equity Considerations

Meaningful health disparities persist across the cervical cancer care continuum, resulting in disproportionate incidence, advanced-stage presentation, and mortality among racially and ethnically minoritized populations and individuals facing

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socioeconomic disadvantage. Black and Hispanic individuals experience higher cervical cancer incidence and mortality compared with non-Hispanic White individuals, with Black patients demonstrating the poorest survival across histologic subtypes and stages, even after accounting for incidence differences (Cohen et al., 2023). Structural factors including lower income, underinsurance, and geographic residence are strongly associated with reduced screening uptake and increased cervical cancer burden, particularly in the Southern United States and in communities with higher levels of neighborhood deprivation (Castellano et al., 2024; Neibart et al., 2025). Although screening is effective in reducing cervical cancer incidence and mortality, disparities in both screening access and timely diagnostic follow-up after abnormal results remain substantial and contribute to later-stage disease at diagnosis (Spencer et al., 2023; Melnikow et al., 2018).

Access to timely, guideline-concordant diagnostic imaging and treatment represents an additional source of inequity. Geographic variation in the availability of specialized oncology services including advanced imaging modalities and brachytherapy centers is associated with higher rates of recurrent or metastatic disease, particularly among patients in rural and low-resource settings who may face transportation, financial, and logistical barriers to care (Castellano et al., 2024; Neibart et al., 2025). Even when screening is completed, downstream inequities such as delays in staging imaging, limited access to MRI or PET/CT, and underuse of brachytherapy disproportionately affect Black, Hispanic, and publicly insured patients, contributing to inferior outcomes (Cohen et al., 2023; Neibart et al., 2025). Ensuring equitable access to evidence-based imaging across all phases of cervical cancer care is critical to reducing preventable disparities and supporting consistent, high-quality oncologic management (Melnikow et al., 2018; Spencer et al., 2023).

Oncology Imaging Guidelines

Cervical Cancer – Suspected/Diagnosis (ONC-23.1)

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Criteria

Indication	Medically Necessary Imaging Study
All individuals with suspected cervical cancer	• Advanced imaging is not considered medically necessary prior to biopsy

Evidence Discussion

The recommendation that advanced imaging is not medically necessary prior to biopsy in suspected cervical cancer is supported by evidence emphasizing that diagnosis is pathologic and not imaging-based. NCCN guidelines specify that the initial evaluation of suspected cervical cancer requires cervical biopsy and histopathologic confirmation, as imaging cannot establish a definitive diagnosis. Imaging prior to biopsy does not improve diagnostic accuracy and may lead to unnecessary utilization of resources. Avoiding routine imaging prior to biopsy also reduces potential harms, including unnecessary radiation exposure, increased healthcare costs, and incidental findings that may lead to additional testing without clinical benefit. Reliance on tissue diagnosis ensures accurate identification of malignancy and histologic subtype before further staging or treatment planning is undertaken (NCCN, 2026).

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Cervical Cancer – Initial Work-Up/ Staging (ONC-23.2)

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Criteria

Indication	Medically Necessary Imaging Study
All individuals with one of the following: • Stage I-IVA cervical cancer • Stage IVB cervical cancer amenable to local treatment	• MRI Pelvis without and with contrast (CPT® 72197)
Stage IB1-IB3 cervical cancer, non-fertility sparing treatment	In addition to MRI Pelvis above, any ONE of the following combinations: • PET/CT (CPT® 78815) or • CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) or • PET/MRI (CPT® 78813 and CPT® 76498)
ANY of the following: • Stage 1B1-IB3 cervical cancer, fertility-sparing treatment • Stage II-IVA cervical cancer • Any size cervical cancer incidentally found in a hysterectomy specimen	In addition to MRI Pelvis above, any ONE of the following combinations: • PET/CT (CPT® 78815) or • CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) or • CT Chest without contrast (CPT® 71250) and CT Abdomen and Pelvis with contrast (CPT® 74177)

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Indication	Medically Necessary Imaging Study
Small cell neuroendocrine carcinoma of the cervix (NECC)	MRI Brain without and with contrast (CPT® 70553) and any ONE of the following combinations: • PET/CT (CPT® 78815) or • CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) or • CT Chest without contrast (CPT® 71250) and CT Abdomen and Pelvis with contrast (CPT® 74177)
Inconclusive findings on conventional imaging in individuals with cervical cancer	• PET/CT (CPT® 78815)

Background and Supporting Information

Cervical cancer staging and initial work-up are guided by tumor extent, histology, and risk of metastatic spread. The International Federation of Gynecology and Obstetrics (FIGO) staging system is used and incorporates both clinical and imaging findings. Imaging plays a central role in determining local tumor extent, nodal involvement, and distant metastases, all of which are critical for treatment planning (NCCN, 2026).

Certain histologic subtypes, such as small cell neuroendocrine carcinoma of the cervix, demonstrate more aggressive behavior and a higher propensity for distant metastases, including central nervous system involvement. These characteristics influence imaging strategies and necessitate more comprehensive staging (NCCN, 2026).

Evidence Discussion

MRI of the pelvis without and with contrast is supported as the primary imaging modality for local staging because of its superior soft tissue resolution and ability to accurately evaluate tumor extent. Evidence demonstrates that MRI provides the most reliable assessment of parametrial invasion, tumor size, and adjacent organ involvement, all of which directly influence treatment selection between surgical and non-surgical approaches. Compared to CT, MRI has higher sensitivity and specificity for evaluating local disease, supporting its use as the foundational imaging study in initial staging (NCCN, 2026).

Systemic imaging with PET/CT or CT of the chest, abdomen, and pelvis is supported for evaluation of nodal and distant metastatic disease, particularly in stage IB and higher disease. NCCN guidelines note that PET/CT is preferred for detecting extra-pelvic disease and guiding treatment decisions, especially when considering definitive local therapies such as surgery or chemoradiation. The ability of PET/CT to identify metabolically active lymph nodes and distant metastases improves staging accuracy and helps avoid inappropriate local treatment in patients with advanced disease. PET/CT is also supported as a problem-solving modality when conventional imaging findings are inconclusive. Its high sensitivity for detecting metabolically active disease provides additional diagnostic clarity in cases where CT or MRI results are equivocal. This targeted use minimizes unnecessary imaging while improving diagnostic confidence and supporting appropriate staging and management decisions (NCCN, 2026).

The use of CT as an alternative imaging modality is supported when PET/CT is not available, although its diagnostic performance is more limited. Evidence demonstrates lower sensitivity for detecting parametrial invasion and nodal disease compared to MRI and PET/CT, but CT remains useful for assessing thoracic and abdominal metastases. Inclusion of chest imaging is important given the potential for pulmonary metastases, particularly in more advanced stages (NCCN, 2026).

For small cell neuroendocrine carcinoma of the cervix, the addition of brain MRI is supported due to the aggressive nature of this histology and higher risk of central nervous system metastases. NCCN recommendations for this subtype are adapted from other neuroendocrine malignancies with known CNS involvement risk. Early identification of brain metastases is clinically important, as it significantly impacts treatment planning and prognosis (NCCN, 2026).

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Cervical Cancer – Restaging/Recurrence (ONC-23.3)

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Criteria

Indication	Medically Necessary Imaging Study
Stage I cervical cancer treated with definitive surgery	• See: **Cervical Cancer – Surveillance (ONC-23.4)**
EITHER of the following: • Stage IB3 cervical cancer • Stage I cervical cancer treated with post-operative adjuvant radiation or chemoradiation due to positive nodes, positive parametria, positive margins, or local cervical factors	• PET/CT (CPT® 78815) 3-6 months post-completion of therapy
Stage II-IV cervical cancer	ONE of the following within 3-6 months of completion of therapy: • PET/CT (CPT® 78815) or • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast)

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Indication	Medically Necessary Imaging Study
Small cell NECC, treated with primary chemoradiation	ONE of the following after completion of therapy: • PET/CT (CPT® 78815) and MRI Brain without and with contrast (CPT® 70553) or • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast and MRI Brain without and with contrast (CPT® 70553)
Inconclusive findings on CT scan or PET/CT in individuals with cervical cancer	MRI Pelvis without and with contrast (CPT® 72197)
Unresectable disease or metastatic disease on systemic treatment in individuals with cervical cancer	Every 2 cycles of treatment (commonly every 6 to 8 weeks): • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of other involved or symptomatic areas
Inconclusive conventional imaging in individuals with cervical cancer	• PET/CT (CPT® 78815)
Suspected or biopsy proven recurrence in individuals with cervical cancer	EITHER of the following, not both: • PET/CT (CPT® 78815) OR • CT Chest (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177)

Background and Supporting Information

Post-treatment evaluation and restaging in cervical cancer are guided by stage at diagnosis, histology, and treatment modality. Following definitive therapy, imaging is used selectively to assess for residual disease, evaluate treatment response, and detect recurrence. The timing and modality of imaging depend on the initial disease stage, presence of risk factors, and treatment approach (NCCN, 2026).

Recurrence patterns include local pelvic recurrence, nodal disease, and distant metastases, with higher-stage disease and high-risk pathologic features associated with

increased recurrence risk. Imaging in the early post-treatment period is most valuable for patients with advanced disease or high-risk features, where it may influence further management (NCCN, 2026).

Aggressive histologic subtypes, such as small cell neuroendocrine carcinoma of the cervix, have a higher likelihood of distant spread, including central nervous system involvement, and therefore require more comprehensive post-treatment imaging evaluation (NCCN, 2026).

Evidence Discussion

Imaging following primary treatment of cervical cancer is supported in individuals with higher-stage disease or high-risk features to evaluate for residual or metastatic disease. NCCN guidelines recommend post-treatment imaging within 3–6 months for stage IB3 or higher disease and for those treated with chemoradiation or adjuvant therapy, as these populations have a higher likelihood of persistent or recurrent disease. The principal benefit of this approach is early identification of residual tumor or distant metastases that may alter management, including escalation to systemic therapy or selection of salvage interventions (NCCN, 2026).

PET/CT is supported as a preferred modality in many post-treatment scenarios due to its ability to detect metabolically active disease and evaluate the whole body for nodal and distant metastases. NCCN guidance indicates that PET/CT is particularly valuable in advanced-stage disease and in the early post-treatment period to rule out extra-pelvic disease before further treatment decisions are made. CT of the chest, abdomen, and pelvis remains an appropriate alternative when PET/CT is unavailable, offering anatomic assessment of thoracic and abdominal disease, though with comparatively lower sensitivity for small or metabolically active lesions (NCCN, 2026).

For aggressive histologies such as small cell neuroendocrine carcinoma of the cervix, the inclusion of brain MRI in restaging is supported due to the higher risk of central nervous system metastases. This recommendation reflects evidence that these tumors behave more aggressively than typical cervical cancers, with early hematogenous spread, and that detection of CNS involvement has a direct impact on treatment planning and prognosis. Additionally, MRI of the pelvis is supported as a problem-solving modality when CT or PET/CT findings are inconclusive, given its superior soft tissue resolution for evaluating local recurrence or residual disease (NCCN, 2026).

Serial CT imaging in patients with unresectable or metastatic disease undergoing systemic therapy is supported for monitoring treatment response, typically at intervals of approximately every 6–8 weeks (every 2 cycles). This approach provides objective and reproducible assessment of disease burden over time, enabling timely identification of progression or response and facilitating appropriate treatment modification. Across all scenarios, limiting imaging to clinically indicated situations, such as high-risk features, treatment monitoring, or suspected recurrence, balances improved detection of clinically

meaningful disease with the potential harms of repeated imaging, including radiation exposure, false-positive findings, and increased healthcare costs (NCCN, 2026).

Oncology Imaging Guidelines

Cervical Cancer – Surveillance (ONC-23.4)

ON.CV.0023.4.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Stage I cervical cancer treated with fertility sparing approach	• MRI Pelvis without and with contrast (CPT® 72197) at 6 months after surgery and then annually for 2-3 years
Small cell NECC	Once, 3-6 months after completion of therapy: • PET/CT (CPT® 78815) Then, every 3 months for 1 year, then every 6 months: • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast and MRI Brain without and with contrast (CPT® 70553)
All other individuals with cervical cancer	• No routine advanced imaging is considered medically necessary in asymptomatic individuals.

Background and Supporting Information

Surveillance following treatment for cervical cancer is primarily guided by clinical evaluation, including history and physical examination, with imaging reserved for specific clinical scenarios. Most recurrences are detected based on symptoms or examination findings rather than routine imaging. The NCCN emphasizes risk-adapted follow-up strategies based on stage, treatment modality, and histology, with imaging used selectively when it is likely to impact management (NCCN, 2026).

Evidence Discussion

The recommendation to perform MRI pelvis imaging at defined intervals following fertility-sparing treatment for stage I cervical cancer is supported by NCCN guidance indicating that MRI provides the most accurate assessment of residual or recurrent local disease in the preserved cervix. MRI's superior soft tissue contrast allows for detailed evaluation of tumor recurrence and anatomical changes after surgery. This targeted use of imaging improves detection of clinically significant recurrence while limiting unnecessary imaging in lower-risk populations (NCCN, 2026).

Oncology Imaging Guidelines

For small cell neuroendocrine carcinoma, more intensive imaging surveillance is supported due to the aggressive biology and high propensity for early distant metastases, including to the brain. NCCN recommends comprehensive imaging, including PET/CT and brain MRI, following completion of therapy. Although specific surveillance intervals are not explicitly defined for this subtype in cervical cancer, extrapolation from neuroendocrine tumor surveillance practices is supported by the similar metastatic patterns and clinical behavior. This approach facilitates early detection of recurrence in a population at high risk for rapid disease progression (NCCN, 2026).

The recommendation against routine advanced imaging in asymptomatic individuals with other cervical cancer histologies is supported by evidence demonstrating limited clinical benefit of imaging in this setting. NCCN indicates that imaging should be based on symptoms or clinical concern for recurrence, as routine imaging has low yield for detecting asymptomatic disease and does not clearly improve survival outcomes. Avoiding routine imaging reduces unnecessary radiation exposure, minimizes false-positive findings, and decreases healthcare costs (NCCN, 2026).

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Anal Cancer & Cancers of the External Genitalia (ONC-24)

Guideline Page

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Anal Carcinoma – General Considerations (ONC-24.0)

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Criteria

- Adenocarcinoma of the anal canal is managed as rectal cancer according to **Colorectal and Small Bowel Cancer (ONC-16)**.
- Squamous cell carcinoma of the perianal region (up to 5cm radius from the anal verge) are imaged according to anal carcinoma guidelines.
- Bowen's disease and Paget's disease of the perianal and perigenital skin are considered non-invasive/in-situ conditions and do not routinely require advanced imaging. See: **Non-Melanoma Skin Cancers – Initial Work-up/Staging (ONC-5.6)**.

Background and Supporting Information

Anal carcinoma is a relatively uncommon malignancy arising from the anal canal or perianal region. The majority of anal cancers are squamous cell carcinomas (SCC), which represent the dominant histologic subtype and are associated with human papillomavirus (HPV) infection. Other less common histologies include transitional or cloacogenic carcinomas, which are now largely grouped under the broader category of squamous cell carcinoma due to similar biological behavior and prognosis (NCCN, 2026).

The anal region includes both the anal canal and perianal skin, which have distinct anatomic and histologic characteristics but may be involved simultaneously by tumor. Squamous cell carcinomas arising within the anal canal or perianal region are managed under anal carcinoma treatment paradigms due to shared biology and patterns of spread, including lymphatic drainage to inguinal and pelvic nodes (NCCN, 2026).

Other malignancies that may occur in the anal region differ significantly in their biology and management. Anal adenocarcinoma originates from glandular epithelium and demonstrates clinical behavior similar to rectal adenocarcinoma. Therefore, these tumors are managed according to colorectal cancer treatment principles rather than anal carcinoma guidelines (NCCN, 2026).

Non-invasive conditions of the perianal skin, including Bowen's disease (squamous cell carcinoma in situ) and Paget's disease, are confined to the epithelium without stromal invasion. These lesions lack metastatic potential and therefore do not require advanced imaging in routine evaluation, with management instead guided by dermatologic and local treatment principles (NCCN, 2026).

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Health Equity Considerations

Anal carcinoma is a relatively rare malignancy, yet its incidence continues to rise disproportionately among populations experiencing socioeconomic disadvantage and structural barriers to care. Epidemiologic studies demonstrate that anal cancer occurs more frequently in communities with higher rates of poverty and greater proportions of racial and ethnic minoritized populations, with substantially higher incidence observed in zip codes characterized by concentrated socioeconomic deprivation (Oliveira et al., 2020). These disparities are compounded by unequal exposure to key risk factors, including higher prevalence of oncogenic human papillomavirus (HPV) infection, immunosuppression, and limited access to preventive services. Globally, inequities in HPV vaccine uptake and cancer surveillance infrastructure further contribute to widening disparities, particularly in low- and middle-income countries where anal cancer incidence is projected to increase as HPV prevalence remains high and vaccination coverage remains limited (Pedersen et al., 2025).

Disparities in outcomes are also driven by differential access to timely diagnosis, staging, and treatment. Populations at highest risk, such as individuals living with HIV, men who have sex with men, and those with prior HPV-related malignancies, often face barriers to early evaluation and consistent follow-up, increasing the likelihood of more advanced disease at presentation (Pedersen et al., 2025). Within the United States, patients residing in structurally disadvantaged communities may experience delays in diagnostic imaging, fragmented care coordination, and reduced access to specialized oncology services, all of which may adversely affect treatment outcomes (Oliveira et al., 2020). Addressing health equity in anal carcinoma requires improving access to preventive strategies, ensuring equitable availability of evidence-based imaging and staging, and supporting health system interventions that reduce diagnostic delays for populations disproportionately burdened by disease (Pedersen et al., 2025).

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Anal Carcinoma – Suspected/Diagnosis (ONC-24.1)

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Criteria

Indication	Medically Necessary Imaging Study
All individuals with suspected anal carcinoma	• No advanced imaging prior to biopsy

Evidence Discussion

The recommendation that no advanced imaging is medically necessary prior to biopsy in suspected anal carcinoma is supported by evidence that diagnosis and initial staging are fundamentally clinical and pathologic processes. NCCN guidelines emphasize that a tissue diagnosis is required, and most anal cancers are staged clinically based on direct physical examination, anoscopy, and histologic confirmation rather than imaging. This approach ensures that diagnosis is accurate and avoids reliance on imaging modalities that cannot definitively distinguish malignant from benign or premalignant lesions (NCCN, 2026).

Advanced imaging prior to biopsy does not improve diagnostic accuracy and may lead to unnecessary testing. Imaging modalities such as CT or PET/CT are intended for evaluation of disease extent after diagnosis, including assessment of nodal involvement and distant metastases, rather than for primary detection. NCCN guidance indicates that imaging is part of the staging work-up after histologic confirmation, reinforcing that biopsy is the essential first step in establishing the presence of malignancy (NCCN, 2026).

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Anal Carcinoma – Initial Work-up/ Staging (ONC-24.2)

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Criteria

Indication	Medically Necessary Imaging Study
All individuals with anal carcinoma	• CT Chest with contrast (CPT® 71260) and Any ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT Abdomen with contrast (CPT® 74160) and MRI Pelvis without and with contrast (CPT® 72197)
• Stage II-III Squamous Cell Carcinoma of the Anal Canal and no evidence of metastatic disease by conventional imaging • Inconclusive findings on conventional imaging in individuals with anal carcinoma	• PET/CT (CPT® 78815)

Background and Supporting Information

Initial work-up and staging of anal carcinoma are based on clinical evaluation combined with imaging to assess local disease extent, nodal involvement, and distant metastases. Anal cancer is most commonly a squamous cell carcinoma and demonstrates characteristic patterns of spread, including regional lymph node involvement and, less commonly, distant metastases to liver and lungs. Accurate staging is essential for treatment planning, as management varies depending on disease extent and presence of metastatic disease (NCCN, 2026; Valvo et al., 2019).

Evidence Discussion

The recommendation for CT chest with contrast and CT abdomen/pelvis with contrast, or CT abdomen with contrast and MRI pelvis, is supported by evidence demonstrating that cross-sectional imaging is necessary to evaluate the extent of disease beyond the

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primary tumor. CT imaging provides critical information regarding distant metastatic spread, including involvement of the lungs, liver, retroperitoneum, and nodal basins, which cannot be determined by physical examination alone. This information directly influences staging and treatment selection, particularly in distinguishing localized from metastatic disease (NCCN, 2026; Valvo et al., 2019).

MRI pelvis is supported as an alternative component of staging due to its superior soft tissue resolution for local tumor assessment. Evidence indicates that MRI is more accurate than CT in evaluating local invasion of adjacent structures, including sphincter muscles and pelvic organs, and in assessing mesorectal lymph nodes. This improved anatomic detail enhances treatment planning, particularly for radiation therapy and organ-preserving approaches (NCCN, 2026; Valvo et al., 2019).

The use of PET/CT in stage II–III disease without evidence of metastasis on conventional imaging, or for inconclusive findings, is supported by evidence demonstrating its added value in detecting nodal and distant disease. PET/CT has been shown to identify metabolically active lymph nodes not detected on CT and to alter nodal status and TNM staging in a substantial proportion of patients, with reported changes in staging in up to 41% of cases. This improved staging accuracy can influence radiation field design and overall treatment strategy, preventing under- or overtreatment. Despite its utility, PET/CT is not recommended as a replacement for diagnostic CT because it may have limitations in detecting small lesions and does not provide the same level of anatomic detail. Therefore, PET/CT is used as a complementary modality rather than a primary staging tool. This approach balances the benefits of improved detection of metabolically active disease with the need to avoid unnecessary imaging, additional radiation exposure, and increased cost when conventional imaging is sufficient (NCCN, 2026; Valvo et al., 2019).

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Anal Carcinoma – Restaging/Recurrence (ONC-24.3)

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Criteria

Indication	Medically Necessary Imaging Study
Stage I anal carcinoma treated with complete surgical resection	• See: **Anal Carcinoma – Surveillance (ONC-24.4)** for surveillance guidelines
Stages I, II and III anal carcinoma – post chemoradiation evaluation	• CT Chest with contrast (CPT® 71260) or without contrast (CPT® 71250) AND any ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Metastatic (stage IV) anal carcinoma	• CT Abdomen and Pelvis with contrast (CPT® 74177) every 2 cycles (generally 6 to 8 weeks) on treatment • CT Chest with contrast (CPT® 71260) if chest x-ray is abnormal or if symptoms of chest involvement
In individuals with anal carcinoma: • Difficult or abnormal examination • Elevated LFTs • Signs or symptoms of recurrence • Biopsy proven recurrence	Preferably using same imaging studies as used in initial imaging: • CT Chest (CPT® 71260) with contrast and Any ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
Individuals with anal carcinoma with biopsy proven recurrence and inconclusive conventional imaging	• PET/CT (CPT® 78815)

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Background and Supporting Information

Anal carcinoma restaging and recurrence evaluation are guided by disease stage, treatment modality, and risk of recurrence. Most anal cancers are squamous cell carcinomas treated with chemoradiation, and clinical response assessment may be delayed due to the known slow tumor regression following therapy. Imaging plays a complementary role to clinical assessment by evaluating residual disease, nodal involvement, and distant metastases, particularly when findings are unclear on examination (NCCN, 2026).

Recurrence patterns include local pelvic recurrence, regional nodal recurrence (inguinal or pelvic nodes), and distant metastases, most commonly involving the liver or lungs. Early-stage disease treated with local excision carries a lower risk of recurrence, while higher-stage disease treated with chemoradiation has a higher likelihood of locoregional or distant relapse. Imaging strategies are tailored accordingly, with more intensive evaluation in higher-risk or symptomatic populations (NCCN, 2026).

Evidence Discussion

The recommendation that stage I anal carcinoma treated with complete surgical resection follow surveillance without routine imaging is supported by NCCN guidance demonstrating a relatively low risk of recurrence in this population. Clinical follow-up with physical examination and anoscopy is the primary method of detecting recurrence. Routine imaging in asymptomatic individuals has limited yield and may expose patients to unnecessary radiation, false-positive findings, and increased cost without improving outcomes (NCCN, 2026).

For stage I–III disease treated with chemoradiation, post-treatment imaging with CT chest and CT abdomen/pelvis or MRI abdomen/pelvis is supported to assess treatment response and identify residual or recurrent disease. NCCN notes that cross-sectional imaging provides important information on locoregional and distant disease that cannot be fully assessed clinically, particularly given the delayed tumor regression characteristic of anal carcinoma. This imaging helps guide decisions regarding continued observation versus biopsy or salvage therapy (NCCN, 2026).

In metastatic (stage IV) disease, serial CT imaging of the abdomen and pelvis every two cycles of systemic therapy is supported for monitoring treatment response and disease progression. CT provides reproducible, objective assessment of tumor burden, enabling timely adjustments in therapy. Chest imaging is performed selectively when clinically indicated (e.g., abnormal chest x-ray or symptoms), reflecting the goal of balancing appropriate disease monitoring with minimization of unnecessary imaging exposure (NCCN, 2026).

For suspected or biopsy-proven recurrence, CT chest combined with CT abdomen/pelvis or MRI abdomen/pelvis is recommended, preferably using the same imaging

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modalities as initial staging to allow accurate comparison over time. PET/CT is supported for biopsy proven recurrence when conventional imaging is inconclusive, as it provides additional functional information that can clarify indeterminate findings. This stepwise imaging approach optimizes diagnostic accuracy while minimizing redundant imaging, radiation exposure, and cost, ensuring imaging is used when it meaningfully impacts patient management (NCCN, 2026).

Oncology Imaging Guidelines

Anal Carcinoma – Surveillance (ONC-24.4)

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Criteria

Indication	Medically Necessary Imaging Study
Stage I anal carcinoma	• Advanced imaging is not routinely considered medically necessary for surveillance
• Stage II anal carcinoma • Stage III anal carcinoma • Local recurrence of anal carcinoma treated definitively	• CT Chest (CPT® 71260) with contrast or CT Chest without contrast (CPT® 71250) annually for 3 years • And ANY one of the following annually for three years: ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Stage IV anal carcinoma – measurable metastatic disease on maintenance treatment or being observed off treatment	Every 3 months for up to 5 years after completion of all treatment: • CT Chest (CPT® 71260) with contrast • CT Abdomen and Pelvis with contrast (CPT® 74177)

Background and Supporting Information

Surveillance after treatment for anal carcinoma is primarily based on clinical evaluation, with imaging used selectively according to stage and risk of recurrence. Most anal cancers are squamous cell carcinomas treated with chemoradiation, and patterns of recurrence include local, regional nodal, and distant metastatic disease. The risk of recurrence varies by stage, with lower risk in stage I disease treated definitively and higher risk in stage II–III and metastatic disease (NCCN, 2026).

Evidence Discussion

The recommendation that advanced imaging is not routinely considered medically necessary for stage I anal carcinoma is supported by NCCN guidance indicating that early-stage disease has a relatively low risk of recurrence following definitive treatment.

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Most recurrences are detected through clinical examination rather than imaging. Routine imaging in asymptomatic individuals has low diagnostic yield and may expose patients to unnecessary radiation, false-positive findings, and increased healthcare costs without improving outcomes (NCCN, 2026).

For stage II–III disease and individuals treated definitively for local recurrence, annual imaging with CT chest (with or without contrast) combined with CT abdomen/pelvis or MRI abdomen/pelvis is supported to detect recurrence or metastatic disease. NCCN recommends cross-sectional imaging annually for 3 years in higher-risk populations, as these patients have a greater likelihood of recurrence, particularly within the first few years after treatment. This imaging provides assessment of distant metastases and complements clinical examination, improving early detection of clinically significant recurrence (NCCN, 2026).

In patients with stage IV disease who have measurable metastatic disease and are on maintenance therapy or observation, more frequent imaging is supported. CT chest and CT abdomen/pelvis every 3 months for up to 5 years allows for close monitoring of disease stability or progression. This frequent surveillance enables timely identification of progression and supports ongoing treatment decision-making. The higher imaging frequency reflects the significantly increased risk of progression in metastatic disease compared to earlier stages (NCCN, 2026).

NCCN specifically notes that FDG PET/CT is not indicated for routine surveillance following definitive treatment of localized disease, as it has not demonstrated additional benefit over conventional imaging in this setting and may increase unnecessary radiation exposure and false-positive findings. Overall, the surveillance strategy balances the benefits of early detection of recurrence in higher-risk populations with the harms of over-imaging in low-risk individuals, ensuring imaging is used when it is most likely to influence clinical management (NCCN, 2026).

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Cancers of External Genitalia – General Considerations (ONC-24.5)

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Criteria

- These imaging guidelines are applicable for squamous cell carcinomas arising from the vulva, vagina, penis, urethra, and scrotum.

Background and Supporting Information

Cancers of the external genitalia encompass malignancies arising from the vulva, vagina, penis, urethra, and scrotum. Across these anatomic sites, squamous cell carcinoma (SCC) is the predominant histologic subtype and forms the basis for unified imaging considerations. These tumors share common etiologic factors, including human papillomavirus (HPV) infection and chronic inflammatory conditions, and demonstrate similar patterns of local invasion and lymphatic spread, particularly to regional inguinal and pelvic lymph nodes (NCCN, 2026).

The external genital anatomy includes cutaneous and mucosal surfaces with distinct lymphatic drainage pathways that converge on regional nodal basins. For example, penile and vulvar cancers commonly spread to inguinal lymph nodes, while vaginal cancers may involve pelvic nodal chains. These shared anatomic and biologic features support a unified conceptual framework for imaging evaluation of squamous malignancies arising in these regions (NCCN, 2026).

Although less common histologies may occur, including adenocarcinoma or melanoma, these entities often require disease-specific management approaches. In contrast, squamous cell carcinomas across external genital sites demonstrate consistent clinical behavior and treatment paradigms, including surgical resection, radiation therapy, and systemic therapy based on stage and nodal involvement (NCCN, 2026).

Health Equity Considerations

Cancers of the external genitalia—including penile, vulvar, and vaginal cancers—are rare malignancies, yet they demonstrate marked and persistent health disparities across racial, ethnic, socioeconomic, and geographic groups. Population-based studies in the United States show substantial variation in incidence and mortality by race and region, with higher incidence of vulvar cancer among White and American Indian/ Alaska Native individuals and higher mortality among Black individuals, particularly for vulvar and vaginal cancers (Zhou & Yue, 2022; Zhang et al., 2025). For penile cancer, Hispanic and Black men experience higher stages at diagnosis and worse survival

despite lower or comparable incidence, reflecting inequities downstream from prevention and early detection (Akinyema et al., 2023; Ogbuji et al., 2024). These patterns are closely tied to social determinants of health, including lower educational attainment, residence in socioeconomically deprived or rural areas, lack of insurance, and reduced access to preventive services such as HPV vaccination and early specialty evaluation (Angulo-Lozano et al., 2022; Mansur et al., 2024).

Disparities are further amplified by unequal access to timely, guideline-concordant diagnostic imaging, staging, and specialty care. Patients from marginalized communities are more likely to experience delays in diagnosis, present with locally advanced or metastatic disease, and require more radical surgical interventions, particularly in penile cancer, where limited access to primary and tertiary care is strongly associated with adverse outcomes and higher mortality (Angulo-Lozano et al., 2022; Ogbuji et al., 2024). Similar patterns are observed in vulvar and vaginal cancers, where Black patients are less likely to receive appropriate multimodal therapy and experience longer delays from diagnosis to treatment, contributing to inferior outcomes even after adjustment for stage (Towner et al., 2022; Zhou & Yue, 2022). Ensuring equitable access to evidence-based imaging, timely staging, and specialized oncologic care alongside prevention strategies such as HPV vaccination and patient education is essential to mitigating disparities and improving outcomes for cancers of the external genitalia (Mansur et al., 2024; Zhang et al., 2025).

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Cancers of External Genitalia – Initial Work-Up/Staging (ONC-24.6)

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Criteria

Indication	Medically Necessary Imaging Study
Clinical node negative **vulvar** cancer with ANY of the following: • Lesion greater than 2cm • Any size with stromal invasion greater than 1mm	• For planned sentinel lymph node evaluation: Lymph system imaging (lymphoscintigraphy, CPT® 78195) ◦ SPECT/CT (CPT® 78830) if requested
For stage II or higher **vulvar** cancer or suspected metastatic vulvar cancer based on one of the following: • Abnormal physical exam findings • Bulky vulvar tumor (≥4cm or close to critical structures) • Vaginal, urethral, or anal involvement • Delay in presentation or treatment • Pelvic, abdominal, or pulmonary symptoms	ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) OR • CT Abdomen with contrast (CPT® 74160) and MRI Pelvis without and with contrast (CPT® 72197) For individuals with signs/symptoms of chest involvement or abnormal findings on chest x-ray: • CT Chest with contrast (CPT® 71260)

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Indication	Medically Necessary Imaging Study
Vaginal carcinoma	ONE of the following combinations: • PET/CT (CPT® 78815) and MRI Pelvis without and with contrast (CPT® 72197) or • CT Abdomen and Pelvis with contrast (CPT® 74177) and CT Chest with contrast (CPT® 71260) or • CT Abdomen with contrast (CPT® 74160) and MRI Pelvis without and with contrast (CPT® 72197) and CT Chest with contrast (71260)
Penile carcinoma with ANY of the following: • Non-palpable inguinal lymph nodes and intermediate or high-risk lesion (T1b or any T2 or greater) • Palpable inguinal lymph nodes • Difficult pelvic node assessment on physical exam	CT Chest with contrast (CPT® 71260) AND Any ONE of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast • CT Abdomen with contrast (CPT® 74160) and MRI Pelvis without and with contrast (CPT® 72197)
In individuals with cancers of the external genitalia: • Inconclusive findings on conventional imaging • Pelvic nodes enlarged but biopsy not technically feasible	• PET/CT (CPT® 78815)

Background and Supporting Information

Initial work-up and staging of cancers of the external genitalia, including vulvar, vaginal, and penile squamous cell carcinomas, require integration of clinical examination and imaging to assess tumor extent, nodal involvement, and distant metastatic disease. These malignancies share common patterns of spread, particularly through lymphatic

pathways to inguinal and pelvic lymph nodes, and staging is critical for determining treatment strategy and prognosis (NCCN, 2026).

Evidence Discussion

The recommendation for lymphoscintigraphy in clinically node-negative vulvar cancer with lesions >2cm or stromal invasion >1mm is supported by NCCN guidance emphasizing the importance of lymphatic spread in vulvar carcinoma. Sentinel lymph node mapping is essential for accurate staging because disease dissemination occurs through superficial lymphatic channels. Lymphatic imaging techniques such as lymphoscintigraphy improve identification of sentinel nodes and guide surgical staging, minimizing unnecessary full lymphadenectomy and associated morbidity while maintaining staging accuracy (NCCN, 2026).

For stage II or higher vulvar cancer or when metastatic disease is suspected, cross-sectional imaging with CT abdomen and pelvis or MRI pelvis (with CT abdomen) is supported to evaluate extent of disease. NCCN notes that imaging is indicated when there are abnormal exam findings, large tumors, or suspicion for local extension or distant metastasis. CT provides comprehensive evaluation for abdominal and pelvic metastases, while MRI offers improved delineation of local tumor invasion and involvement of adjacent structures. CT chest is recommended when symptoms or abnormal chest imaging suggest thoracic involvement, ensuring targeted evaluation while avoiding unnecessary imaging in asymptomatic individuals (NCCN, 2026).

In vaginal carcinoma, NCCN identifies PET/CT as the preferred imaging modality for evaluation of metastatic disease, with CT chest/abdomen/pelvis as an acceptable alternative. PET/CT offers improved detection of metabolically active nodal and distant disease compared with conventional imaging. MRI pelvis is recommended in conjunction with PET/CT or CT to assess local tumor extent, as it provides superior soft tissue resolution for defining tumor size, depth, and involvement of adjacent pelvic organs. The combination of metabolic and anatomic imaging improves staging accuracy and informs treatment planning (NCCN, 2026).

For penile carcinoma, cross-sectional imaging of the chest, abdomen, and pelvis with CT or MRI is supported in patients with intermediate- or high-risk primary tumors, palpable lymph nodes, or difficulty in clinical nodal assessment. NCCN emphasizes that inguinal lymph node status is the most important prognostic indicator in penile cancer, and imaging is critical when nodal involvement is suspected or cannot be adequately assessed on examination. MRI provides additional information regarding depth of tumor invasion, while CT is useful for assessing nodal and distant disease (NCCN, 2026).

PET/CT is recommended as a problem-solving tool for inconclusive findings on conventional imaging or when pelvic nodes are enlarged but biopsy is not technically feasible. NCCN notes that PET/CT has higher sensitivity in patients with node-positive disease and can detect metabolically active nodes not identified on CT or MRI.

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However, PET/CT is not used as a first-line modality in all cases due to limitations in detecting small-volume disease and higher cost and radiation exposure. Its selective use balances improved diagnostic accuracy with the need to avoid unnecessary imaging (NCCN, 2026).

Oncology Imaging Guidelines

Cancers of External Genitalia – Restaging/Recurrence (ONC-24.7)

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Criteria

Indication	Medically Necessary Imaging Study
In individuals with cancers of external genitalia: • Difficult or abnormal examination • Elevated LFTs • Signs or symptoms of recurrence • Biopsy proven recurrence	• CT Chest with contrast (CPT® 71260) And ANY one of the following: • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast
EITHER of the following in individuals with cancers of the external genitalia: • individuals receiving systemic treatment for measurable disease • At the end of definitive therapy	Any ONE of the following, every 2 cycles (generally 6 to 8 weeks) during treatment at the end of planned chemotherapy treatment: • CT Abdomen and Pelvis with contrast (CPT® 74177) or • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast or • CT Abdomen with contrast (CPT® 74160) and MRI Pelvis (CPT® 72197) AND • CT Chest with contrast (CPT® 71260)
Vaginal primary tumor treated with upfront radiation therapy	• PET/CT (CPT® 78815) at least 12 weeks after completion of radiation therapy ◦ MRI Pelvis without and with contrast (CPT® 72197) is medically necessary if PET/CT not available (can be performed sooner than 12 weeks after completion of therapy) ◦ MRI Pelvis without and with contrast (CPT® 72197) is medically necessary for clarification of PET/CT findings

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Indication	Medically Necessary Imaging Study
Vulvar carcinoma following definitive primary therapy with chemoradiation or surgery	3-6 months after primary therapy: • MRI Pelvis without and with contrast (CPT® 72197)
Inconclusive findings on conventional imaging in individuals with cancers of the external genitalia	• PET/CT (CPT® 78815)

Background and Supporting Information

Restaging and recurrence evaluation in cancers of the external genitalia, including vulvar, vaginal, and penile squamous cell carcinomas, relies on imaging to assess treatment response, detect residual disease, and identify locoregional or distant recurrence. These malignancies share common recurrence patterns involving the primary site, regional lymph nodes (inguinal and pelvic), and distant organs such as the lungs and liver (NCCN, 2026.

Evidence Discussion

The use of CT chest combined with CT abdomen/pelvis or MRI abdomen/pelvis for individuals with suspected or confirmed recurrence is supported by NCCN guidance indicating that imaging should be performed in the presence of abnormal examination findings, symptoms, or biochemical abnormalities. These modalities provide comprehensive assessment of locoregional and distant disease, including evaluation of lung, liver, and nodal metastases, which are common sites of spread in external genital malignancies. This approach ensures accurate detection of recurrence while avoiding unnecessary imaging in asymptomatic patients (NCCN, 2026).

For individuals receiving systemic therapy or undergoing post-treatment evaluation, serial imaging every 2 cycles is supported to monitor treatment response and disease progression. NCCN guidance emphasizes that cross-sectional imaging provides objective and reproducible assessment of tumor burden over time, allowing timely adjustments in therapy. This structured interval balances the need for close monitoring of active disease with the risks of repeated imaging, including radiation exposure and cost (NCCN, 2026).

In vaginal carcinoma treated with radiation therapy, PET/CT is supported at least 12 weeks after treatment completion to assess response. NCCN notes that delayed imaging reduces false-positive findings related to post-radiation inflammation and improves diagnostic accuracy for residual disease. MRI pelvis is recommended when

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PET/CT is unavailable or for clarification of indeterminate findings due to its superior soft tissue resolution for evaluating local tumor extent (NCCN, 2026).

For vulvar carcinoma following definitive therapy, MRI pelvis at 3–6 months is supported to assess local treatment response and reevaluate lymph node involvement. MRI provides detailed anatomic information that is critical for distinguishing residual tumor from post-treatment changes. PET/CT is reserved for inconclusive findings on conventional imaging, as it offers functional assessment of disease activity but is not routinely required in all cases due to cost, radiation exposure, and potential false positives. This stepwise imaging strategy maximizes diagnostic accuracy while minimizing unnecessary imaging (NCCN, 2026).

Oncology Imaging Guidelines

Cancers of External Genitalia – Surveillance (ONC-24.8)

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Criteria

Indication	Medically Necessary Imaging Study
• All stages of vulvar and vaginal cancers	• See: **ONC-24.7** for post-treatment imaging 3-6 months after completion of therapy. No additional routine advanced imaging for asymptomatic surveillance.
• Penile Cancer: stage I-IIIA	• CT Abdomen and Pelvis with contrast (CPT® 74177) every 6 months for 2 years, and then every 12 months for 2 years
• Penile cancer: stages IIIB-IV	• CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) every 3 months for one year, then every 6 months for 3 more years

Background and Supporting Information

Surveillance of cancers of the external genitalia, including vulvar, vaginal, and penile squamous cell carcinomas, is guided by stage, tumor biology, and risk of recurrence. These malignancies share patterns of recurrence involving the primary site, regional lymph nodes (especially inguinal and pelvic nodes), and distant metastases such as lung or liver involvement. Clinical follow-up with history and physical examination is the cornerstone of surveillance, with imaging used selectively based on risk and symptoms (NCCN, 2026).

Evidence Discussion

The recommendation that no routine advanced imaging is considered medically necessary for surveillance of vulvar and vaginal cancers in asymptomatic individuals is supported by NCCN guidance emphasizing the primary role of clinical evaluation in follow-up. Evidence indicates that most recurrences are detected through physical examination or symptom assessment rather than imaging. Routine imaging has low diagnostic yield in this population and may introduce harms such as radiation exposure,

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false-positive findings, and increased healthcare costs without improving survival outcomes (NCCN, 2026).

For penile cancer stage I–IIIA, surveillance imaging with CT abdomen and pelvis at defined intervals is supported due to the risk of nodal and distant recurrence. NCCN guidance indicates that cross-sectional imaging is useful for detecting asymptomatic disease, particularly in patients at intermediate risk of recurrence. While chest imaging may be performed with radiography in some cases, CT abdomen and pelvis provides more comprehensive evaluation of retroperitoneal and pelvic lymph nodes, which are common sites of disease progression (NCCN, 2026).

In higher-stage penile cancer (stage IIIB–IV), more intensive surveillance with CT chest and CT abdomen and pelvis is supported due to the significantly increased risk of distant metastases, including pulmonary involvement. NCCN recommendations reflect the aggressive nature of advanced disease and the need for closer monitoring, particularly in the first years following treatment when recurrence risk is highest. More frequent imaging allows for earlier detection of progression and facilitates timely intervention, which may impact prognosis and treatment options (NCCN, 2026).

Overall, the surveillance imaging strategy reflects a risk-adapted approach. Limiting imaging in vulvar and vaginal cancers reduces unnecessary interventions and associated harms in low-risk, asymptomatic populations, while structured imaging in penile cancer, especially advanced stages, enhances detection of clinically significant recurrence. This approach balances the benefits of early detection with the risks of over-imaging, including radiation exposure, incidental findings, and increased cost, ensuring imaging is used when it is most likely to influence clinical management (NCCN, 2026).

Oncology Imaging Guidelines

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Multiple Myeloma and Plasmacytomas (ONC-25)

Guideline Page

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Multiple Myeloma and Plasmacytomas – General Considerations (ONC-25.0)

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Criteria

- Multiple myeloma group of disorders can be classified as below, which influence imaging modality of choice.

Condition	Monoclonal protein	Bone marrow plasma cells	CRAB criteria**
Solitary Plasmacytoma (biopsy proven tumor containing plasma cells)	<3gm/dL	Absent	Absent
Monoclonal Gammopathy of Unknown Significance (MGUS)	<3gm/dL	<10%	Absent
Smoldering Myeloma (SMM) (stage I MM or asymptomatic MM)	≥3gm/dL	10% - 60%	Absent
Multiple Myeloma (MM)	≥3gm/dL	≥10%	Present

**CRAB criteria = hypercalcemia, renal insufficiency, anemia, lytic bony lesions

- Diagnosis and monitoring of response to therapy is primarily with laboratory studies that include urine and serum monoclonal protein levels, serum-free light chain levels, LDH and beta-2 microglobulin. Routine advanced imaging to monitor response to treatment is not considered medically necessary.
- Rarely, (<5%), an individual may have nonsecretory myeloma, which does not produce measurable M-protein. These individuals require imaging as primary method to monitor disease.
- Other conditions that may present with monoclonal gammopathy include:
  - POEMS syndrome: Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein and Skin Changes – may also have sclerotic bone lesions and Castleman's disease. See: **Multiple Myeloma and Plasmacytomas – Initial Work-up/Staging (ONC-25.2)** for imaging recommendations.

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- Waldenström's Macroglobulinemia: IgM monoclonal protein along with bone marrow infiltration of small lymphocytes. See: **Waldenström Macroglobulinemia or Lymphoplasmacytic Lymphoma (ONC-27.10)** for imaging recommendations.
- Systemic Light chain Amyloidosis: light chain monoclonal protein in serum or urine with clonal plasma cells in bone marrow, systemic involvement of the kidneys, liver, heart, gastrointestinal tract or peripheral nerves due to amyloid deposition. See: **Multiple Myeloma and Plasmacytomas – Initial Work-up/Staging (ONC-25.2), Multiple Myeloma and Plasmacytomas - Restaging/Recurrence (ONC-25.3)**, and **Multiple Myeloma and Plasmacytomas - Surveillance (ONC-25.4)** for imaging recommendations for systemic light chain amyloidosis. See **Myocardial Tc-99m Pyrophosphate Imaging in Cardiac Amyloidosis (CD-3.8)** for cardiac amyloidosis.

Background and Supporting Information

Multiple myeloma (MM) is a neoplastic disorder characterized by the proliferation of a single clone of plasma cells derived from B cells which grows in the bone marrow and adjacent bone, producing skeletal destruction. End-organ damage is classically defined by CRAB criteria (hypercalcemia, renal insufficiency, anemia, and lytic bone lesions), which distinguish symptomatic multiple myeloma from precursor states. The disease spectrum includes monoclonal gammopathy of undetermined significance (MGUS), smoldering multiple myeloma (SMM), solitary plasmacytoma, and overt symptomatic multiple myeloma, which are differentiated by monoclonal protein levels, bone marrow plasma cell percentage, and the presence or absence of myeloma-defining events (NCCN, 2026).

Diagnosis and monitoring of multiple myeloma rely primarily on laboratory studies, including serum and urine protein electrophoresis, immunofixation, serum free light chains, and other biochemical markers such as beta-2 microglobulin and lactate dehydrogenase. These laboratory parameters are essential for staging, risk stratification, and assessment of treatment response. Imaging plays a complementary role, particularly for detecting bone disease and assessing disease burden, but is not the primary modality for routine monitoring in most patients (NCCN, 2026).

A small subset of patients have nonsecretory myeloma, characterized by the absence of measurable monoclonal protein in serum or urine. In these patients, imaging assumes a greater role in disease evaluation, as laboratory markers are not reliable indicators of disease burden (NCCN, 2026).

Other plasma cell-related disorders, including POEMS syndrome, Waldenström macroglobulinemia, and systemic light chain amyloidosis, may present with monoclonal gammopathy but have distinct clinical features, organ involvement, and imaging considerations. These conditions are managed according to separate disease-specific

pathways based on their unique biology and patterns of systemic involvement (NCCN, 2026).

Health Equity Considerations

Multiple myeloma (MM) and plasmacytomas demonstrate some of the most pronounced and well-documented health inequities among hematologic malignancies, particularly in the United States. Black individuals experience approximately double the incidence of MM compared with White individuals and are diagnosed at younger ages, yet repeatedly face systemic barriers to timely, high-quality care, including lower rates of novel agent use, delayed treatment initiation, and reduced access to autologous stem cell transplantation (ASCT) (Gasoyan et al., 2024; Mateos et al., 2023). A comprehensive U.S. systematic review found that racial disparities were reported in over three-quarters of studies examining MM treatment patterns, with inequities also strongly associated with insurance type, geographic distance from care centers, and socioeconomic status (Gasoyan et al., 2024). Importantly, evidence from equal-access systems consistently shows that when Black patients receive comparable therapy, survival is equivalent or superior to that of White patients, underscoring that observed outcome disparities largely reflect inequitable access rather than biological differences alone (Gasoyan et al., 2024; Mateos et al., 2023).

Disparities extend across the full continuum of MM care, including diagnostic evaluation, imaging surveillance, treatment selection, and supportive care, all areas directly relevant to oncology imaging guidelines. Low socioeconomic status, inadequate insurance coverage, rural residence, and longer travel distances to specialty centers are associated with reduced access to advanced imaging, delayed staging, lower utilization of ASCT, and less frequent use of guideline-recommended supportive measures (Gasoyan et al., 2024). Globally, similar patterns emerge, with older age, female sex, minority race/ethnicity, and lower socioeconomic status consistently linked to poorer access to treatment and worse outcomes, although the magnitude and drivers of disparity vary by health system (Mateos et al., 2023). Ensuring equitable access to evidence-based imaging, critical for diagnosis, staging, treatment response assessment, and detection of skeletal and extramedullary disease, requires attention to modifiable structural barriers, including insurance design, prior authorization requirements, geographic access to advanced imaging, and inclusion of underrepresented populations in clinical trials. Addressing these factors is essential to achieving equitable outcomes in MM and plasmacytomas and to realizing the full benefits of modern myeloma therapies across all populations (Gasoyan et al., 2024; Mateos et al., 2023).

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Multiple Myeloma and Plasmacytomas – Suspected/Diagnosis (ONC-25.1)

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See: **Initial Work-up/Staging (ONC-25.2)**

Oncology Imaging Guidelines

Multiple Myeloma and Plasmacytomas – Initial Work-Up/Staging (ONC-25.2)

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v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Either of the following: • Confirmed myeloma • Myeloma suspected (to include smoldering and MGUS) based on any of the following: ◦ Abnormal skeletal survey or other imaging ◦ Abnormal myeloma labs ◦ Signs/symptoms of multiple myeloma	EITHER of the following: • Whole-body low-dose skeletal CT (CPT® 76497) or • Whole-body FDG PET/CT (CPT® 78816)
Inconclusive findings on whole-body low-dose skeletal CT in individuals with multiple myeloma and plasmacytomas	• PET/CT (CPT® 78815 or CPT® 78816)
To discern smoldering myeloma from active myeloma and whole-body CT or PET are negative or inconclusive	ONE of the following: • MRI Bone Marrow Blood Supply (CPT® 77084) • Whole-body MRI (CPT® 76498) • CT contrast as requested of a specific area to determine radiotherapy or surgical candidacy, or for suspected extra-osseous plasmacytoma
Initial work-up of suspected or known POEMS syndrome or monoclonal gammopathy of neurological significance (MGNS)	• CT Chest with contrast (CPT® 71260) and • CT Abdomen and Pelvis with contrast (CPT® 74177) • Whole-body FDG PET/CT (CPT® 78816) for sclerotic bone lesions on other imaging

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Indication	Medically Necessary Imaging Study
Initial work-up of suspected or known systemic light chain amyloidosis	• Whole-body low-dose skeletal CT (CPT® 76497) OR Whole-body FDG PET/CT (CPT® 78816) • Additional imaging, base on suspected organ involvement: ◦ CT Chest with contrast (CPT® 71260) ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) For additional imaging related to cardiac involvement, see: **Cardiac Amyloidosis (CD-3.8)**

Background and Supporting Information

Multiple myeloma (MM) is a clonal plasma cell malignancy defined by proliferation of plasma cells in the bone marrow and the presence of myeloma-defining events, including CRAB criteria or biomarkers such as focal lesions on MRI. The disease exists along a spectrum that includes monoclonal gammopathy of undetermined significance (MGUS), smoldering myeloma (SMM), solitary plasmacytoma, and symptomatic MM, which are differentiated by laboratory findings, bone marrow involvement, and end-organ damage (NCCN, 2026). Imaging plays a central role in initial work-up and staging, particularly for detection of lytic bone lesions and extramedullary disease.

Related plasma cell disorders such as POEMS syndrome, monoclonal gammopathy of neurological significance (MGNS), and systemic light chain amyloidosis may involve systemic organs and demonstrate distinct imaging findings. These conditions often require additional cross-sectional imaging to evaluate organ involvement or atypical skeletal findings beyond lytic lesions (NCCN, 2026).

Evidence Discussion

The recommendation for whole-body low-dose CT or whole-body FDG PET/CT as the initial imaging modality in suspected or confirmed multiple myeloma is supported by NCCN guidance identifying both as preferred for initial diagnostic work-up. These modalities provide sensitive detection of osteolytic lesions, which are a defining feature of symptomatic myeloma and are required for accurate staging. Compared with skeletal survey, whole-body imaging improves lesion detection and allows more accurate assessment of total disease burden, directly impacting diagnosis and treatment decisions (NCCN, 2026).

The use of PET/CT for inconclusive findings on whole-body low-dose CT is supported by its ability to detect metabolically active disease. NCCN notes that FDG-PET/CT can identify otherwise unrecognized lesions and residual disease and has prognostic importance, as persistent FDG-avid lesions are associated with worse outcomes. This supports PET/CT as a secondary or problem-solving modality when CT findings are indeterminate, rather than a universal replacement for CT (NCCN, 2026).

MRI is supported when CT or PET/CT findings are negative or inconclusive in order to distinguish smoldering myeloma from active myeloma. NCCN specifies that more than one focal lesion on MRI is considered a myeloma-defining biomarker, and MRI is therefore critical in identifying early marrow involvement not visualized on CT. This improves diagnostic accuracy, ensuring appropriate classification of patients and preventing both underdiagnosis of active disease and overtreatment of smoldering disease (NCCN, 2026).

The recommendation for CT chest, abdomen, and pelvis or PET/CT in POEMS syndrome, MGNS, and systemic light chain amyloidosis is supported by the systemic nature of these disorders. NCCN indicates that these conditions frequently involve lymph nodes, visceral organs, or sclerotic bone lesions, necessitating cross-sectional imaging beyond skeletal evaluation. Tailoring imaging to the clinical presentation ensures comprehensive assessment of disease extent while avoiding unnecessary or misdirected imaging, thereby balancing diagnostic benefit with potential harms such as radiation exposure and incidental findings (NCCN, 2026).

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Multiple Myeloma and Plasmacytomas – Restaging/Recurrence (ONC-25.3)

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Criteria

Indication	Medically Necessary Imaging Study
Extra-osseous plasmacytoma response to initial therapy in individuals with multiple myeloma and plasmacytomas	Repeat imaging with ONE of the following, whichever modality was used at initial diagnosis: • Whole-body low-dose skeletal CT scan (CPT® 76497) • Whole-body FDG PET/CT (CPT® 78816) • Whole-body MRI (CPT® 76498) • CT of any previously involved area, contrast as requested • MRI of any previously involved area, contrast as requested
Known spine involvement with new neurological signs/symptoms or worsening pain in individuals with multiple myeloma and plasmacytomas	• MRI Cervical (CPT® 72156), Thoracic (CPT® 72157), Lumbar spine (CPT® 72158) without and with contrast
Treatment response assessment in individuals with multiple myeloma and plasmacytomas: • After completion of primary therapy • Non-secretory multiple myeloma • To determine therapy response with inconclusive labs	Repeat imaging with ONE of the modalities below, whichever was used at initial diagnosis: • Whole-body low-dose skeletal CT scan (CPT® 76497) • Whole-body FDG PET/CT (CPT® 78816)

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Indication	Medically Necessary Imaging Study
CAR-T cell therapy in individuals with multiple myeloma and plasmacytomas	Once before treatment and once 30-60 days after completion of treatment: • PET/CT (CPT® 78815 or CPT® 78816) Once at baseline prior to therapy if required by institutional protocol, and at any time for any new neurological symptoms: • MRI Brain without and with contrast (CPT® 70553)
ANY of the following in individuals with multiple myeloma and plasmacytomas: • Suspected progression or relapse/recurrence • Suspected progression of MGUS or SMM to a more malignant form	ONE of the following (using same modality as used at diagnosis): • Whole-body low-dose skeletal CT (CPT® 76497) • Whole-body FDG PET/CT (CPT® 78816) • Whole-body MRI (CPT® 76498)
ANY of the following in individuals with multiple myeloma and plasmacytomas: • Negative PET will allow change in management from active treatment to maintenance or surveillance. • Inconclusive findings on conventional imaging • Whole-body low-dose skeletal CT (CPT® 76497) is unfeasible and recurrence or progression is suspected	• PET/CT (CPT® 78815 or CPT® 78816)
To discern smoldering myeloma from active myeloma and whole-body CT or PET are negative or inconclusive	ONE of the following: • MRI Bone Marrow Blood Supply (CPT® 77084) • Whole-body MRI (CPT® 76498) • MRI without contrast, or MRI without and with contrast for any previously involved bony area or symptomatic area (including whole spine for spinal symptoms)

Indication	Medically Necessary Imaging Study
Stem cell transplant recipients	ONE of the following, once before transplant and once within 30-100 days after transplant: Imaging should use same modality as initial diagnosis. • Whole-body low-dose skeletal CT scan (CPT® 76497) • MRI Bone Marrow Blood Supply (CPT® 77084) • Whole-body MRI (CPT® 76498) • PET/CT (CPT® 78815 or CPT® 78816)

Background and Supporting Information

Multiple myeloma (MM) and plasmacytomas are plasma cell disorders characterized by clonal proliferation of plasma cells with potential for skeletal involvement, extramedullary disease, and systemic complications. Disease status following treatment is assessed using a combination of laboratory markers and imaging, with imaging playing a complementary role in select clinical scenarios such as suspected progression, non-secretory disease, or evaluation of treatment response when biochemical parameters are inconclusive (NCCN, 2026). Restaging and recurrence evaluation are guided by clinical context, including symptoms, laboratory findings, and prior imaging results.

Evidence Discussion

The recommendation to repeat imaging using the same modality as used at initial diagnosis for assessment of extra-osseous plasmacytoma response and for suspected progression or recurrence is supported by NCCN guidance emphasizing consistency of imaging techniques. NCCN states that follow-up imaging should preferably use the same modality as baseline to allow accurate longitudinal comparison. This approach improves detection of response or progression by minimizing variability between imaging studies and enhances clinical decision-making (NCCN, 2026).

MRI of the cervical, thoracic, or lumbar spine for new neurologic symptoms or worsening pain in individuals with known spinal involvement is supported by NCCN recommendations that MRI provides superior evaluation of bone marrow and soft tissue structures. MRI is particularly sensitive for detecting spinal cord compression, nerve root involvement, and progression of marrow disease. Its use in symptomatic individuals allows rapid diagnosis of clinically significant complications and facilitates timely intervention, which is critical to prevent permanent neurologic deficits (NCCN, 2026).

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Repeat whole-body imaging (low-dose CT, PET/CT, or MRI) for treatment response assessment, particularly after completion of therapy, in non-secretory myeloma, or when laboratory markers are inconclusive, is supported by NCCN guidance that imaging should be performed "as needed" in follow-up. NCCN highlights that residual focal lesions detected on PET/CT or MRI are associated with adverse prognostic significance, supporting the role of imaging in selected scenarios where laboratory monitoring is insufficient. This ensures appropriate evaluation of disease status while avoiding unnecessary routine imaging in patients adequately monitored with laboratory studies (NCCN, 2026).

The use of PET/CT as a problem-solving modality in cases of inconclusive conventional imaging or when evaluating suspected recurrence is supported by its ability to identify metabolically active disease. NCCN notes that PET/CT can detect lesions not identified on CT and can clarify indeterminate findings, which may directly influence management decisions, including the distinction between active treatment and surveillance. Similarly, MRI is supported for distinguishing smoldering myeloma from active disease when CT or PET/CT findings are negative or inconclusive, as MRI can detect focal marrow lesions that represent myeloma-defining events (NCCN, 2026).

Finally, imaging before and after major treatment interventions such as stem cell transplant or CAR-T cell therapy is supported to establish baseline disease burden and assess response. NCCN indicates that imaging findings contribute to evaluation of treatment effectiveness and may have prognostic implications. The selective use of imaging in these scenarios balances the benefits of accurate disease assessment with the risks of overuse, including radiation exposure, cost, and incidental findings (NCCN, 2026).

Multiple Myeloma and Plasmacytomas – Surveillance (ONC-25.4)

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Criteria

Indication	Medically Necessary Imaging Study
• Smoldering myeloma • Multiple myeloma	ANY ONE of the following (using same imaging modality used at diagnosis) annually: • Whole-body low-dose skeletal CT (CPT® 76497) • MRI Bone Marrow Blood Supply (CPT® 77084) • Whole-body MRI (CPT® 76498) • Whole-body FDG PET/CT (CPT® 78816)
Solitary plasmacytomas	Any ONE of the following (using same imaging modality used at diagnosis) annually for 5 years: • Whole-body low-dose skeletal CT (CPT® 76497) • MRI Bone Marrow Blood Supply (CPT® 77084) • Whole-body MRI (CPT® 76498) • Whole-body FDG PET/CT (CPT® 78816)
Individuals with MGUS	No further advanced imaging is considered medically necessary beyond baseline unless there are signs and symptoms of progression

Background and Supporting Information

Multiple myeloma (MM) is a plasma cell malignancy characterized by clonal proliferation within the bone marrow and progressive skeletal involvement, which represents a key feature of disease burden and progression. Imaging is central to the evaluation of bone disease, as lytic lesions and bone marrow infiltration are major components of disease activity and are required for diagnosis and treatment decision-making (Perillo et al., 2024; NCCN, 2026).

Imaging also plays an important role in longitudinal disease monitoring, particularly for identifying progression, detecting new lesions, and evaluating treatment response. Given the chronic nature of MM and the potential for progression from smoldering disease or solitary plasmacytoma, periodic imaging using consistent modalities is important to assess disease stability and guide management (Perillo et al., 2024; NCCN, 2026).

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Evidence Discussion

The recommendation for annual surveillance imaging using the same modality as at diagnosis in smoldering myeloma and multiple myeloma is supported by evidence that bone disease is a predominant and progressive feature of MM, occurring in the majority of patients over time. Imaging is essential for detecting lytic lesions, which represent end-organ damage and may prompt treatment initiation or modification. Cross-sectional imaging modalities such as CT, PET/CT, and MRI are more sensitive than radiography for detecting skeletal lesions, enabling earlier identification of disease progression and clinically meaningful changes (Perillo et al., 2024; Dimopoulos et al., 2015).

Whole-body low-dose CT is supported as an effective surveillance modality due to its ability to detect osteolytic lesions throughout the skeleton with high accuracy and relatively low radiation dose. Compared with conventional skeletal survey, WBLDCT demonstrates increased sensitivity for bone disease and can identify lesions that may alter disease management or prevent skeletal-related complications. Its speed, accessibility, and cost-effectiveness further support its role in longitudinal surveillance (Terao & Matsue, 2022; Perillo et al., 2024).

FDG PET/CT is supported for its ability to detect metabolically active disease and identify extramedullary involvement, which is associated with poorer prognosis. PET/CT provides both functional and anatomical information and is more sensitive than CT alone for detecting extramedullary disease. Additionally, PET/CT plays a role in distinguishing between smoldering and active myeloma and may identify early progression, supporting its inclusion as an appropriate surveillance option when used consistently with baseline imaging (Cavo et al., 2017; Perillo et al., 2024).

MRI, including whole-body MRI and diffusion-weighted MRI, is supported as the most sensitive modality for detecting bone marrow infiltration, including lesions not yet associated with cortical destruction. MRI can identify early disease progression and has prognostic value, as patterns of marrow involvement and ADC measurements correlate with disease severity and outcomes. Advanced MRI techniques, including diffusion-weighted imaging and synthetic MRI parameters, enable assessment of treatment response and disease burden at a cellular level, making MRI particularly valuable for surveillance and risk stratification (Costachescu et al., 2021; Cui et al., 2024; Perillo et al., 2024).

For solitary plasmacytomas, the recommendation for annual imaging for 5 years is supported by the risk of progression to multiple myeloma and the need for ongoing assessment of both local disease control and development of systemic involvement. Using the same imaging modality as at diagnosis allows accurate comparison over time and improves detection of new lesions or progression. Across all surveillance strategies, limiting imaging frequency to annual intervals balances the benefit of early detection of progression with the potential harms of repeated imaging, including radiation exposure

(for CT and PET/CT), cost, and false-positive findings, while still ensuring appropriate monitoring of disease status (Perillo et al., 2024; NCCN, 2026).

Oncology Imaging Guidelines

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Leukemias, Myelodysplasia and Myeloproliferative Neoplasms (ONC-26)

Guideline Page

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Leukemias, Myelodysplasia, and Myeloproliferative Neoplasms – General Considerations (ONC-26.1)

ON.LM.0026.1.A
v1.0.2027

Criteria

- Routine advanced imaging is not considered medically necessary for the evaluation and management of hairy cell leukemia in the absence of specific localizing clinical symptoms.

Background and Supporting Information

Hairy cell leukemia (HCL) is a rare, indolent B-cell lymphoid malignancy characterized by infiltration of the bone marrow and spleen, frequently presenting with pancytopenia, splenomegaly, and minimal lymphadenopathy. It accounts for approximately 2% of all leukemias and demonstrates a chronic clinical course with long survival, often managed with intermittent therapy or observation depending on symptom burden (NCCN, 2026; PDQ Adult Treatment Editorial Board, 2025).

Diagnosis and management of HCL rely primarily on hematologic evaluation, including peripheral blood smear, bone marrow biopsy, immunophenotyping, and molecular testing such as detection of the BRAF V600E mutation. Clinical assessment and laboratory studies are central to disease evaluation, while imaging is considered optional and typically reserved for selected clinical circumstances (NCCN, 2026; PDQ Adult Treatment Editorial Board, 2025).

The clinical course of HCL is often indolent, and many patients can be managed with a "watchful waiting" approach until symptomatic disease or cytopenias develop. Treatment decisions are driven by clinical findings such as progressive cytopenias, splenomegaly, recurrent infections, or systemic symptoms rather than imaging findings (Troussard et al., 2024; NCCN, 2026).

Evidence Discussion

The recommendation that routine advanced imaging is not medically necessary for the evaluation and management of hairy cell leukemia in the absence of specific localizing clinical symptoms is supported by NCCN and PDQ guidance emphasizing that diagnosis and disease monitoring are primarily based on clinical and laboratory parameters. Key diagnostic tools include peripheral blood evaluation, bone marrow

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biopsy, immunophenotyping, and molecular testing, rather than imaging (NCCN, 2026; PDQ Adult Treatment Editorial Board, 2025).

The limited role of imaging also reflects the typical disease distribution in HCL, which preferentially involves the bone marrow and spleen and rarely presents with significant lymphadenopathy. Because disease burden is most accurately assessed through hematologic parameters and bone marrow evaluation, routine advanced imaging provides limited incremental diagnostic value. Imaging may be used selectively in atypical presentations or complex cases, but its routine use is not supported by evidence (PDQ Adult Treatment Editorial Board, 2025; Troussard et al., 2024).

Avoidance of routine advanced imaging minimizes potential harms, including radiation exposure, false-positive findings, unnecessary downstream testing, and increased healthcare costs. By reserving imaging for patients with specific localizing symptoms or unusual clinical findings, the recommended approach aligns with evidence-based, risk-adapted care while maintaining diagnostic accuracy and patient safety (NCCN, 2026; PDQ Adult Treatment Editorial Board, 2025; Troussard et al., 2024).

Oncology Imaging Guidelines

Acute Leukemias (ONC-26.2)

ON.LM.0026.2.A
v1.0.2027

Criteria

- Imaging indications for acute lymphoblastic leukemia in adult individuals are identical to those for pediatric individuals. See: **Acute Lymphoblastic Leukemia (ALL) (PEDONC-3.2)** in the Pediatric and Special Populations Oncology Imaging Guidelines.
- Imaging indications for acute myeloid leukemia in adult individuals are identical to those for pediatric individuals. See: **Acute Myeloid Leukemia (AML) (PEDONC-3.3)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

Background and Supporting Information

Acute leukemias, including acute lymphoblastic leukemia (ALL) and acute myeloid leukemia (AML), are aggressive hematologic malignancies characterized by clonal proliferation of immature blast cells in the bone marrow, blood, and extramedullary sites. Diagnosis relies on hematopathologic evaluation, including bone marrow biopsy, immunophenotyping, cytogenetic analysis, and molecular testing, which together inform classification, risk stratification, and treatment planning (NCCN, 2026).

Health Equity Considerations

Equitable care for acute leukemias, including acute myeloid leukemia (AML) and acute lymphoblastic leukemia (ALL), is influenced not only by disease biology but also by a complex interplay of sociodemographic and health system factors. Although treatment paradigms emphasize cytogenetics, molecular risk, and patient fitness, substantial evidence demonstrates that race, ethnicity, and socioeconomic status independently impact survival and access to care (Hibbs, 2021). Minority populations, including Black and Hispanic patients, often experience poorer outcomes despite similar or even favorable biologic risk profiles, and are frequently diagnosed at younger ages yet have worse survival, suggesting the influence of structural inequities rather than biology alone (Bencomo-Alvarez et al., 2021; Dong et al., 2024; Hibbs, 2021). Socioeconomic disadvantage, including lower income, limited insurance coverage, and reduced access to specialized centers, has been consistently associated with inferior outcomes and reduced likelihood of receiving intensive or potentially curative therapies such as hematopoietic stem cell transplantation (Dong et al., 2024; Hibbs, 2021). Additional barriers, including language proficiency, health literacy, and immigration status, may delay diagnosis, disrupt treatment continuity, and limit engagement in complex care pathways (Bencomo-Alvarez et al., 2021; Hibbs, 2021).

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Disparities are further reinforced by inequities in access to clinical trials and emerging therapies. Analyses of U.S. acute leukemia trials demonstrate that non-Hispanic White patients are disproportionately enrolled compared with Black, Hispanic, Asian, and Native American populations, even after adjusting for disease incidence (Hantel et al., 2021). This underrepresentation limits the generalizability of trial results and restricts equitable access to novel therapies at the forefront of leukemia care (Hantel et al., 2021). Structural and logistical barriers, such as rapid treatment timelines, inpatient treatment settings, and unequal access to tertiary centers, can further hinder trial participation among underserved populations (Hantel et al., 2021). At the patient level, social determinants including housing instability, transportation challenges, comorbidities, and environmental exposures contribute to higher treatment-related morbidity and reduced survival (Bencomo-Alvarez et al., 2021; Hibbs, 2021). Recognition of these multilevel disparities, including differences in treatment access, trial participation, and social support, is essential when considering imaging, staging, and longitudinal management strategies for patients with acute leukemias to ensure equitable care delivery and outcomes across diverse populations.

Oncology Imaging Guidelines

Chronic Myeloid Leukemias, Myelodysplastic Syndrome, and Myeloproliferative Disorders (ONC-26.3)

ON.LM.0026.3.A
v1.0.2027

Criteria

- Routine advanced imaging is not considered medically necessary in the evaluation and management of chronic myeloid leukemias, myelodysplastic syndromes or myeloproliferative disorders in the absence of specific localizing clinical symptoms or clearance for hematopoietic stem cell transplantation.
- See: **Hematopoietic Stem Cell Transplantation (ONC-29)** for imaging guidelines related to transplant.
- For work-up of elevated blood counts, see: **Paraneoplastic Syndromes – General Considerations (ONC-30.3)**.

Background and Supporting Information

Chronic myeloid leukemias, myelodysplastic syndromes (MDS), and myeloproliferative neoplasms (MPN) are hematologic malignancies characterized by clonal proliferation of myeloid lineage cells with variable degrees of marrow dysfunction, cytopenias, or cytoses. Diagnosis and classification rely on integration of clinical findings, peripheral blood evaluation, bone marrow morphology, cytogenetic abnormalities, and molecular testing (NCCN, 2026).

Initial evaluation and monitoring of these disorders are primarily laboratory-based, including complete blood counts, bone marrow biopsy, and molecular profiling (e.g., JAK2, CALR, MPL mutations in MPN and gene mutation panels in MDS). Physical examination findings such as splenomegaly and symptom burden are also important in disease assessment. Imaging is not routinely required for diagnosis but may be used selectively to evaluate organ involvement or complications when clinically indicated (NCCN, 2026).

Myeloproliferative neoplasms and related myeloid disorders may demonstrate risk stratification based on clinical and molecular features, including prognostic scoring systems such as DIPSS, MIPSS, and IPSS-R. These risk models guide therapeutic decisions and follow-up strategies, further emphasizing that disease monitoring is driven primarily by clinical and laboratory parameters rather than routine imaging (NCCN, 2026).

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Evidence Discussion

The recommendation that routine advanced imaging is not medically necessary in the evaluation and management of chronic myeloid leukemias, myelodysplastic syndromes, and myeloproliferative disorders is supported by NCCN guidance indicating that diagnosis, staging, and monitoring are primarily based on hematologic, cytogenetic, and molecular assessments. For MDS and MPN, evaluation centers on complete blood counts, bone marrow aspiration and biopsy, and molecular testing to establish clonality and risk stratification, with imaging not included as a standard component of routine work-up (NCCN, 2026).

The limited role of imaging is further supported by the availability of highly sensitive laboratory and molecular techniques, including next-generation sequencing and cytogenetics, which provide detailed information on disease burden, clonality, and progression risk. These modalities allow clinicians to monitor disease course and response to therapy with greater precision than imaging, reducing the need for routine cross-sectional imaging and reinforcing a laboratory-based monitoring paradigm (NCCN, 2026).

Health Equity Considerations

Chronic myeloid leukemia (CML), myelodysplastic syndromes (MDS), and myeloproliferative disorders (MPD) demonstrate substantial inequities in incidence, stage at diagnosis, and outcomes across geographic, socioeconomic, and demographic groups. Global Burden of Disease analyses show that while higher–socio-demographic index (SDI) countries bear the greatest absolute disease burden, largely due to aging populations and improved diagnostic capacity, patients in low- and low-middle SDI regions experience disproportionately higher mortality-to-incidence ratios, reflecting delayed diagnosis, limited access to specialized hematopathology services, and restricted availability of disease-modifying therapies (Passera, 2025; Gou et al., 2025). Older adults, particularly in rural or resource-limited settings, face additional barriers related to comorbidities, limited health literacy, transportation challenges, and reduced access to longitudinal monitoring, all of which can delay appropriate imaging evaluation and treatment initiation (Obeagu & Parray, 2026). In the United States, persistent geographic and rural–urban disparities in myeloid leukemia mortality further highlight inequitable access to specialized oncology care, with higher mortality rates observed in rural and Midwestern populations (Lehn et al., 2025).

Racial and sociodemographic disparities also influence disease classification, surveillance, and outcomes in MDS and related disorders. Population-based analyses demonstrate differences in disease subtypes, diagnostic coding, and survival by race, suggesting possible underdiagnosis, misclassification, or biologic and structural contributors to inequity (Lesegretain et al., 2023). Additionally, differences in access to molecular testing, critical for diagnosis and risk stratification, may result in less frequent

or delayed use of guideline-concordant imaging and monitoring among underserved populations. Ensuring equitable application of imaging guidelines requires awareness of these disparities, incorporation of risk-based evaluation strategies, and flexibility in imaging pathways for patients facing access barriers. Addressing health equity in these disorders necessitates improved access to hematologic expertise, diagnostic infrastructure, and supportive care, alongside efforts to standardize high-quality evaluation across diverse clinical settings (Passera, 2025; Gou et al., 2025; Obeagu & Parray, 2026).

Oncology Imaging Guidelines

Chronic Lymphocytic Leukemia (CLL)/ Small Lymphocytic Lymphoma (SLL) (ONC-26.4)

ON.LM.0026.4.A
v1.0.2027

Criteria

- PET imaging is not considered medically necessary in the evaluation of CLL/SLL with the exception of suspected Richter's transformation (see suspected transformation, below).
- CLL/SLL is monitored with serial laboratory studies. Routine advanced imaging is not considered medically necessary for monitoring treatment response or surveillance, except when initial studies reveal bulky disease involvement.
- Bulky disease is defined as lymph node mass greater than 10cm or spleen greater than 6cm below costal margin.

Indication	Medically Necessary Imaging Study
Initial Staging/Diagnosis of CLL/SLL	• Routine advanced imaging is not considered medically necessary for initial evaluation of asymptomatic individuals
For ANY of the following in individuals with CLL/SLL: • Bulky lymph node mass (>10cm) • Splenomegaly >6cm below costal margin • Presence of B symptoms • Progressive anemia and thrombocytopenia • Prior to planned systemic therapy	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
Treatment Response in individuals with CLL/SLL	• For individuals with bulky nodal disease at diagnosis, CT with contrast of previously involved area(s) every 2 cycles of therapy • Routine imaging is not considered medically necessary for individuals without bulky nodal disease at diagnosis

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Indication	Medically Necessary Imaging Study
End of Therapy Evaluation in individuals with CLL/SLL	• For individuals with bulky nodal disease at diagnosis, CT with contrast of previously involved area(s)
Suspected Progression in individuals with CLL/SLL	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s)
Suspected transformation (Richter's) from a low-grade lymphoma to a more aggressive type based on one or more of the following: • New B symptoms • Rapidly growing lymph nodes • Extranodal disease develops • Significant recent rise in LDH above normal range	• PET/CT (CPT® 78815 or CPT® 78816)
Surveillance in individuals with CLL/SLL	For individuals with bulky nodal disease at diagnosis, every 6 months for two years, then annually: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s) Routine imaging is not considered medically necessary for individuals without bulky nodal disease at diagnosis

Background and Supporting Information

Chronic lymphocytic leukemia (CLL) and small lymphocytic leukemia (SLL) are indolent B-cell lymphoproliferative disorders characterized by clonal expansion of mature lymphocytes in the peripheral blood, bone marrow, and lymphoid tissues. Diagnosis is established by peripheral blood flow cytometry demonstrating a characteristic

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immunophenotype, with SLL requiring tissue biopsy for confirmation. Staging and risk stratification are based on clinical and laboratory parameters, including cytopenias, lymphocyte count, and molecular features such as cytogenetics and TP53 mutation status (NCCN, 2026).

Evaluation and monitoring of CLL/SLL are primarily laboratory-based, relying on serial complete blood counts, metabolic panels, and molecular testing. Clinical examination, including assessment of lymphadenopathy and splenomegaly, is central to disease monitoring. Routine imaging is not required for diagnosis or surveillance in asymptomatic individuals and is reserved for selected clinical scenarios such as bulky disease, symptoms, or treatment planning (NCCN, 2026).

Evidence Discussion

The recommendation that PET imaging is not medically necessary in the evaluation of CLL/SLL, except in suspected Richter transformation, is supported by NCCN guidance indicating that PET/CT has limited utility in routine CLL management due to the typically low metabolic activity of indolent disease. PET/CT is specifically recommended when transformation to aggressive lymphoma is suspected, as increased FDG uptake can identify high-grade disease and guide biopsy of the most metabolically active lesion, improving diagnostic accuracy (NCCN, 2026).

The guidance that CLL/SLL is monitored with serial laboratory studies and that routine advanced imaging is not medically necessary for treatment response or surveillance is supported by the central role of laboratory and clinical parameters in disease monitoring. NCCN emphasizes that complete blood counts, biochemical markers, and clinical examination provide sufficient information for assessing disease status and progression in most patients. Routine imaging does not improve clinical outcomes in asymptomatic individuals and may lead to unnecessary radiation exposure and incidental findings (NCCN, 2026).

The selective use of CT imaging in individuals with bulky disease, symptoms, or prior to systemic therapy is supported by NCCN recommendations that CT can be useful to assess extent of lymphadenopathy and organ involvement, particularly when there is concern for tumor lysis syndrome or mass effect. Bulky disease (e.g., large lymph node masses or significant splenomegaly) may influence treatment planning and risk stratification, justifying targeted imaging in these situations while avoiding routine use in lower-risk patients (NCCN, 2026).

The recommendation for imaging in suspected progression or recurrence, as well as for suspected Richter transformation, reflects the need for targeted diagnostic evaluation when clinical changes occur. PET/CT is particularly valuable in suspected transformation, where higher FDG uptake correlates with aggressive histology and guides biopsy, while CT is appropriate for assessment of disease burden and progression. Restricting imaging to these clinically indicated scenarios balances the

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benefit of identifying clinically significant disease changes with the risks of over-imaging, including radiation exposure, cost, and downstream diagnostic interventions (NCCN, 2026).

Health Equity Considerations

Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) demonstrates persistent health inequities across racial, socioeconomic, and geographic groups, despite substantial improvements in survival following the introduction of targeted therapies. Population-based analyses using Surveillance, Epidemiology, and End Results (SEER) data consistently show that Black patients and those residing in lower neighborhood socioeconomic strata experience inferior overall survival compared with White patients, even in the post-2014 era when Bruton tyrosine kinase (BTK) and BCL2 inhibitors are widely available (Kittai et al., 2022). These disparities are closely linked to structural factors, including delayed access to specialty oncology care, underutilization of academic treatment centers, and financial barriers to high-cost oral therapies. Real-world cohort data suggest that when access to hematologic care and modern small-molecule inhibitors is comparable, racial differences in overall survival are substantially attenuated, underscoring access to care rather than race as a primary driver of outcome inequities (Kittai et al., 2024). Variations in disease presentation, including higher-risk prognostic features at diagnosis and shorter time to treatment initiation among Black patients, further highlight the need for equitable diagnostic evaluation and longitudinal disease monitoring.

Equity considerations in CLL/SLL extend beyond survival outcomes to include patient-reported quality-of-life (QoL), which is increasingly recognized as a key dimension of care in a disease frequently managed with prolonged active surveillance. Sex-specific disparities in QoL have been documented, with women experiencing significantly worse social, emotional, and overall well-being during surveillance compared with men, while reporting improved QoL once structured treatment and regular clinical engagement are initiated (Mahameed et al., 2025). These findings suggest that reduced clinical contact inherent to surveillance strategies may disproportionately affect certain patient populations, particularly women, through unmet psychosocial and supportive care needs. For imaging guidelines, awareness of these inequities is important to support individualized, guideline-concordant evaluation that accounts for differences in access, symptom burden, and supportive care infrastructure. Incorporating health equity considerations into imaging pathways may help mitigate disparities in disease assessment and ensure consistent monitoring across diverse patient populations (Kittai et al., 2022; Kittai et al., 2024; Mahameed et al., 2025).

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Non-Hodgkin Lymphomas (ONC-27)

Guideline Page

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Non-Hodgkin Lymphomas – General Considerations (ONC-27.1)

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Criteria

- Individuals with AIDS-related lymphoma should be imaged according to the primary lymphoma histology.
- See: **Castleman's Disease (unicentric and multicentric) (ONC-31.11)** for guidelines covering Castleman's disease.
- See: **Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) (ONC-26.4)** for guidelines covering Chronic Lymphocytic Leukemia (CLL)/ Small Lymphocytic Lymphoma (SLL).

Indication	Medically Necessary Imaging Study
• Biopsy proven lymphoma, or • Suspected lymphoma and any of the following: ◦ Bulky lymphadenopathy (LN mass >10cm) ◦ Hepatomegaly ◦ Splenomegaly ◦ B symptom: Unexplained fever, drenching night sweats, unintended weight loss >10% total body weight	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast ◦ MRI without and with contrast for individuals who cannot tolerate CT contrast due to allergy or impaired renal function
Signs or symptoms of non-Hodgkin lymphomas involving the neck	• CT Neck with contrast (CPT® 70491)
Signs or symptoms suggesting CNS involvement with lymphoma	• MRI Brain without and with contrast (CPT® 70553) • See: **CNS Lymphoma (also known as Microglioma) (ONC-2.7)**

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Indication	Medically Necessary Imaging Study
Known or suspected bone involvement with lymphoma	• MRI without and with contrast of symptomatic or previously involved bony areas ◦ Bone scan is inferior to MRI for evaluation of known or suspected bone involvement with lymphoma
Determine a more favorable site for biopsy when a relatively inaccessible site is contemplated in individuals with non-Hodgkin lymphomas	• PET/CT (CPT® 78815 or CPT® 78816) ◦ PET/CT is not considered medically necessary for all other indications prior to histological confirmation of lymphoma
CAR-T cell therapy in individuals with non-Hodgkin lymphomas	Once before treatment and once 30-60 days after completion of treatment: • PET/CT (CPT® 78815 and CPT® 78816) Once at baseline prior to therapy if required by institutional protocol, and at any time for any new neurological symptoms: • MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Non-Hodgkin lymphomas (NHL) represent a heterogeneous group of lymphoid malignancies with variable clinical behavior ranging from indolent to aggressive disease. Clinical presentation frequently includes lymphadenopathy, splenomegaly, hepatomegaly, or systemic "B symptoms" such as fever, night sweats, and weight loss. Diagnosis requires histopathologic confirmation through biopsy, with immunophenotyping and molecular studies used to determine subtype and guide management (NCCN, 2026).

Evidence Discussion

The recommendation to perform CT chest, abdomen, and pelvis with contrast in individuals with biopsy-proven lymphoma or suspected lymphoma with bulky lymphadenopathy, hepatomegaly, splenomegaly, or B symptoms is supported by NCCN guidance indicating that cross-sectional imaging is essential for staging and evaluation of disease extent when there is clinical concern for systemic involvement. CT imaging

provides anatomic assessment of nodal and extranodal disease, which is critical for staging, treatment planning, and risk stratification (NCCN, 2026).

The selective use of additional imaging based on symptoms, such as CT neck for cervical involvement and MRI brain for suspected central nervous system involvement, is consistent with NCCN recommendations that imaging should be directed by clinical presentation. These targeted imaging approaches improve diagnostic yield by focusing on areas of suspected disease while avoiding unnecessary imaging in asymptomatic regions (NCCN, 2026).

MRI for evaluation of suspected bone involvement is supported by NCCN guidance indicating that MRI provides superior sensitivity for detecting marrow infiltration compared with other imaging modalities. In cutaneous and other lymphomas, imaging for bone involvement is performed when clinically indicated rather than routinely, reinforcing a symptom-directed approach to imaging utilization (NCCN, 2026).

The recommendation that PET/CT is not routinely required prior to histologic confirmation but may be used to guide biopsy in cases where a more accessible or metabolically active site is needed is supported by NCCN guidance that FDG-PET/CT is most appropriately used after diagnosis or in selected pre-diagnostic scenarios. PET/CT can identify sites of higher metabolic activity, improving the likelihood of diagnostic yield when biopsying difficult-to-access lesions; however, routine use prior to diagnosis is not supported due to lack of specificity and potential for false-positive findings. Finally, the use of PET/CT in the context of CAR-T therapy is supported by NCCN guidance that imaging before and after therapy is necessary to establish baseline disease burden and assess response. Across all scenarios, the criteria emphasize a risk-adapted and symptom-directed approach to imaging that balances the benefits of accurate staging and disease assessment with the potential harms of unnecessary imaging, including radiation exposure, incidental findings, and increased healthcare utilization (NCCN, 2026).

Health Equity Considerations

Non-Hodgkin lymphomas (NHLs) exhibit substantial and persistent disparities in incidence, mortality, and survival that are closely linked to race, socioeconomic status, sex, and geography. In the United States, population-based analyses demonstrate that Black patients with NHL experience significantly worse survival compared with non-Hispanic White patients, even after adjustment for stage, treatment modality, age, and sex, highlighting inequities that extend beyond disease biology alone (Abodunrin et al., 2022). Insurance status is a critical modifier of outcomes, with publicly insured and uninsured individuals experiencing markedly higher mortality across racial and ethnic groups, reflecting barriers to timely diagnosis, access to subspecialty care, and receipt of guideline-concordant therapy (Abodunrin et al., 2022). National mortality trends further show higher age-adjusted NHL-related death rates among men, residents of

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nonmetropolitan areas, and individuals living in specific geographic regions, particularly parts of the Midwest, underscoring the role of structural, regional, and healthcare access factors in shaping outcomes (Saad et al., 2025).

From a global perspective, inequities in NHL burden are strongly associated with socioeconomic development and healthcare infrastructure. High–socio-demographic index (SDI) regions demonstrate higher incidence and prevalence, likely reflecting improved diagnostic capacity and imaging availability, while low-SDI regions bear a disproportionate share of mortality and disability-adjusted life years due to delayed diagnosis, limited access to advanced imaging, and constrained treatment options (Wang et al., 2025). These global patterns emphasize that disparities in NHL outcomes are driven both by underdiagnosis in resource-limited settings and by unequal access to timely staging, response assessment, and surveillance imaging worldwide. These findings reinforce the importance of promoting equitable access to appropriate imaging modalities across diverse populations and care settings. Consistent application of evidence-based imaging can help reduce delays in diagnosis and staging, support more accurate risk stratification, and mitigate downstream inequities in treatment and survival for patients with NHL (Abodunrin et al., 2022; Saad et al., 2025; Wang et al., 2025).

Oncology Imaging Guidelines

Diffuse Large B Cell Lymphoma (DLBCL) (ONC-27.2)

ON.TO.0027.2.A
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Criteria

- Grey zone lymphomas, primary mediastinal B cell lymphomas, Grade 3 (high) follicular lymphoma, double-hit or triple-hit lymphomas, and primary cutaneous diffuse large B cell lymphoma should also be imaged according to these guidelines.

Indication	Medically Necessary Imaging Study
Initial staging/ diagnosis of diffuse large B Cell lymphoma	ONE of the following:* • PET/CT (CPT® 78815 or CPT® 78816) OR • CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) *PET/CT and diagnostic CT are not considered medically necessary concurrently; however, if CT was performed prior to diagnosis, a PET/CT may be subsequently medically necessary.
Treatment response for all stage I, and stage II diffuse large B cell lymphoma without extensive mesenteric disease	ANY of the following: • CT with contrast of previously involved area(s) may be approved every 2 cycles (6-8 weeks) of therapy • PET/CT (CPT® 78815 or CPT® 78816) after 3-4 cycles of chemotherapy
Treatment response for stage II diffuse large B cell lymphoma WITH extensive mesenteric disease, and stages III-IV	ANY of the following: • CT with contrast of previously involved area(s) may be approved every 2 cycles (6-8 weeks) of therapy • PET/CT (CPT® 78815 or CPT® 78816) after 2-4 cycles of chemotherapy

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Indication	Medically Necessary Imaging Study
End of Chemotherapy and/or Radiation Therapy Evaluation in individuals with diffuse large B cell lymphoma	ANY or ALL of the following: • PET/CT (CPT® 78815 or CPT® 78816) at the end of chemotherapy and again at the end of radiation • CT with contrast of previously involved area(s)
Suspected Recurrence in individuals with diffuse large B cell lymphoma	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s) • PET/CT can be considered in rare circumstances (e.g., bone involvement).
Biopsy-proven recurrence in individuals with diffuse large B cell lymphoma	• PET/CT (CPT® 78815 or CPT® 78816)
CAR-T cell therapy in individuals with diffuse large B cell lymphoma	Once before treatment and once 30-60 days after completion of treatment: • PET/CT (CPT® 78815 or CPT® 78816) Once at baseline prior to therapy if required by institutional protocol, and at any time for any new neurological symptoms: • MRI Brain without and with contrast (CPT® 70553)

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Indication	Medically Necessary Imaging Study
Surveillance in individuals with diffuse large B cell lymphoma for ANY of the following: • All stages of DLBCL • Relapsed lymphoma • Primary mediastinal large B cell lymphoma • Primary cutaneous diffuse large B cell lymphoma	• Every 6 months for 2 years after completion of treatment: ◦ CT Chest with contrast (CPT® 71260) ◦ CT Abdomen and Pelvis with contrast (CPT® 74177) ◦ CT with contrast of previously involved area(s)

Background and Supporting Information

Diffuse large B-cell lymphoma (DLBCL) is an aggressive, FDG-avid non-Hodgkin lymphoma characterized by rapidly proliferating malignant B cells with nodal and extranodal involvement. Diagnosis requires histopathologic confirmation, and staging incorporates clinical features and imaging-defined disease distribution using systems such as the Ann Arbor classification (Cheson et al., 2014; NCCN, 2026).

Evidence Discussion

The recommendation to use either PET/CT or contrast-enhanced CT for initial staging reflects evidence that the majority of DLBCL cases are FDG-avid and that both modalities provide clinically meaningful staging information. PET/CT improves detection of nodal and extranodal disease and establishes a metabolic baseline for subsequent response assessment, while CT remains acceptable when PET/CT is unavailable or previously performed. Importantly, PET/CT has not been consistently shown to be more accurate than CT for initial staging alone but provides added value by improving downstream response evaluation and prognostic assessment (Cheson et al., 2014; Barrington et al., 2016).

The use of CT every 2 cycles of therapy and PET/CT at defined intervals during treatment aligns with evidence demonstrating the complementary roles of anatomic and metabolic imaging. Interim PET/CT provides early assessment of treatment response and correlates with outcomes, while CT allows serial measurement of disease burden. PET/CT is particularly valuable at the end of therapy, where it demonstrates greater

accuracy than CT in distinguishing residual active disease from post-treatment changes, supporting its role as the standard modality for remission assessment (Cheson et al., 2014).

For suspected recurrence, CT is supported for evaluation of disease burden, while PET/CT is reserved for select circumstances such as suspected bone involvement or biopsy-proven relapse. PET/CT improves detection of metabolically active disease and may guide biopsy site selection by identifying areas of highest activity. This targeted use balances diagnostic yield with the higher radiation exposure and cost associated with PET/CT compared with CT alone (Cheson et al., 2014).

The recommendation for PET/CT before and after CAR-T therapy is supported by the prognostic value of FDG avidity. Imaging establishes baseline disease burden and evaluates treatment response, which may guide subsequent therapeutic decisions in relapsed or refractory disease. FDG uptake has been associated with outcomes and may help identify candidates for additional salvage therapies (Cheson et al., 2014; El-Galaly et al., 2015).

Surveillance recommendations limiting imaging to CT every 6 months for 2 years reflect evidence that most relapses occur within this period, while also acknowledging the lack of demonstrated survival benefit from routine surveillance imaging. Multiple studies have shown that routine CT or PET/CT surveillance detects only a minority of relapses and does not improve overall survival compared with clinical follow-up. Relapses are most frequently identified through symptoms, physical examination, or laboratory abnormalities (El-Galaly et al., 2015; Mascaró-Pol et al., 2021). The harms of routine surveillance imaging include radiation exposure, false-positive findings, unnecessary biopsies, increased healthcare costs, and patient anxiety. PET/CT has false-positive rates exceeding 20% in some studies, and CT-based surveillance exposes patients to cumulative radiation doses associated with potential long-term malignancy risk. Additionally, observational data demonstrate no improvement in survival with imaging-based follow-up strategies, supporting a more selective approach focused on clinically indicated imaging (Lynch et al., 2014; Mascaró-Pol et al., 2021).

Health Equity Considerations

Diffuse large B-cell lymphoma (DLBCL) is associated with persistent and clinically meaningful survival disparities related to race, socioeconomic status, and comorbid conditions, despite advances in immunochemotherapy. In U.S.-based community and population studies, Black/African American patients with DLBCL experience significantly worse overall survival compared with non-Black patients, even in the rituximab era and after adjusting for standard prognostic indices such as the Revised International Prognostic Index (R-IPI) (Tiu et al., 2021). These disparities are multifactorial and reflect higher burdens of adverse clinical features at presentation, including elevated lactate dehydrogenase, increased B symptoms, higher prevalence of HIV infection, malnutrition,

and delayed receipt or non-receipt of curative-intent therapy. Insurance status and access to timely oncology care further contribute, with publicly insured or uninsured patients demonstrating worse outcomes than those with private insurance, underscoring the role of structural and socioeconomic barriers rather than disease biology alone (Tiu et al., 2021).

Globally, health inequities in DLBCL are even more pronounced in low- and middle-income countries, where limited diagnostic infrastructure, delayed treatment initiation, and constrained access to rituximab and supportive care result in markedly inferior survival. In resource-limited settings, five-year overall survival remains low, with advanced stage at diagnosis, elevated LDH, treatment delays, and HIV co-infection independently associated with increased mortality (Kassaw et al., 2026). HIV-positive patients, in particular, experience substantially worse outcomes due to compounded immunosuppression, higher rates of treatment toxicity, and gaps in integrated HIV–oncology care. For imaging guideline development, these inequities highlight the importance of supporting equitable access to accurate staging, response assessment, and surveillance imaging, especially for populations at risk for delayed diagnosis or fragmented care. Ensuring consistent, guideline-concordant imaging across diverse care settings may help mitigate downstream disparities in treatment planning and outcomes while acknowledging broader systemic factors that influence DLBCL prognosis (Tiu et al., 2021; Kassaw et al., 2026).

Oncology Imaging Guidelines

Follicular Lymphoma (ONC-27.3)

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Criteria

- This section applies to follicular lymphomas with WHO grade of 1 (low) or 2 (intermediate) and primary cutaneous follicle center lymphoma. Grade 3 (high) follicular lymphomas should be imaged according to guidelines found in: **Diffuse Large B Cell Lymphoma (DLBCL) (ONC-27.2)**.

Indication	Medically Necessary Imaging Study
Initial staging/diagnosis of follicular lymphomas	EITHER of the following: • CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) OR • PET/CT (CPT® 78815)
For ANY of the following in individuals with follicular lymphoma, if PET/CT has not yet been performed: • If radiation therapy is being considered for stage I or II disease • CT results lead to a plan for systemic therapy	• PET/CT (CPT® 78815 or CPT® 78816)
Treatment response in individuals with follicular lymphoma	• CT with contrast of previously involved area(s) every 2 cycles of therapy

Oncology Imaging Guidelines

Indication	Medically Necessary Imaging Study
End of active therapy evaluation (typically approximately 6 cycles) in individuals with follicular lymphoma	ONE of the following may be approved: • PET/CT (CPT® 78815 or CPT® 78816) OR • CT Chest with contrast (CPT® 71260) and • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s)
Suspected recurrence in individuals with follicular lymphoma	ANY or ALL of the following may be approved: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s)
Suspected transformation (Richter's) from a low grade lymphoma to a more aggressive type based on one or more of the following: • New B symptoms • Rapidly growing lymph nodes • Extranodal disease develops • Significant recent rise in LDH above normal range	• PET/CT (CPT® 78815 or CPT® 78816)
Surveillance in individuals with follicular lymphoma for ANY of the following: • After completion of active treatment • On maintenance treatment • Observation without any treatment	For all stages, every 6 months for two years, then annually: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s)
Surveillance of pediatric-type follicular lymphoma in adults	Routine advanced imaging is not considered medically necessary after complete response

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Background and Supporting Information

Follicular lymphoma (FL) is an indolent B-cell non-Hodgkin lymphoma characterized by a relapsing and remitting clinical course with variable disease burden and risk of transformation to aggressive lymphoma. The clinical course of FL may include histologic transformation to aggressive lymphoma, which is associated with worse outcomes (Barrington et al., 2014; Cheson et al., 2014; NCCN, 2026).

Evidence Discussion

The recommendation to use either diagnostic CT or PET/CT for initial staging is supported by evidence that both modalities provide clinically meaningful information in follicular lymphoma. PET/CT improves detection of nodal and extranodal disease compared with CT alone and can alter staging in a minority of cases, while CT provides adequate anatomic staging when PET is not performed. Baseline PET/CT is particularly valuable when systemic therapy is planned or when radiation therapy is considered for early-stage disease, as it establishes a metabolic reference for subsequent response assessment (Barrington et al., 2014; Cheson et al., 2014; NCCN, 2026).

For treatment response assessment, the recommendation to perform CT every 2 cycles is supported by evidence demonstrating that interim PET/CT has limited prognostic reliability in FL compared with aggressive lymphomas. While PET/CT can provide early metabolic information, studies show that interim PET findings are less consistently associated with outcomes, supporting the use of CT for serial evaluation during therapy. In contrast, end-of-treatment PET/CT provides improved sensitivity and specificity for detecting residual disease, with studies demonstrating that PET reclassifies a substantial proportion of patients deemed non-complete response by CT into complete metabolic remission, thereby improving risk stratification and guiding subsequent management (Dupuis et al., 2012; Barrington et al., 2014).

The recommendation for PET/CT in suspected transformation is supported by evidence that increased FDG uptake correlates with aggressive histology. Studies demonstrate that an SUV greater than 10 is highly predictive of aggressive lymphoma, and PET/CT is valuable for identifying the most metabolically active lesion to target biopsy. However, PET findings alone are not diagnostic of transformation and must be confirmed histologically, supporting its role as a targeted diagnostic adjunct rather than a stand-alone test (Noy et al., 2009; Barrington et al., 2014).

Surveillance recommendations reflect limited evidence for routine imaging benefit in indolent lymphomas. Most relapses occur within the first 2 years after treatment, supporting periodic CT during this interval and less frequent imaging thereafter. PET/CT is not recommended for routine surveillance due to false-positive rates approaching 20%, which may lead to unnecessary biopsies, additional imaging, increased costs, and patient anxiety without demonstrated survival benefit. Studies of lymphoma surveillance imaging similarly show no clear improvement in survival with routine imaging compared

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with clinical follow-up, supporting a risk-adapted approach (Lynch et al., 2014; Dupuis et al., 2012; NCCN, 2026).

The exception for pediatric-type follicular lymphoma is supported by evidence indicating no survival benefit from surveillance imaging compared with clinical detection of recurrence. Across all scenarios, the criteria balance the benefits of early detection of clinically significant disease with the harms of over-imaging, emphasizing selective use of PET/CT and structured CT surveillance aligned with disease biology and risk of relapse (NCCN, 2026; Lynch et al., 2014).

Health Equity Considerations

Follicular lymphoma (FL) demonstrates persistent disparities in survival that are strongly associated with socioeconomic status, geography, and access to care, despite overall improvements in outcomes in the modern treatment era. Population-based analyses from California show that although survival has improved across racial and ethnic groups following the introduction of rituximab-based therapies, patients residing in lower-income neighborhoods experience significantly worse overall and disease-specific survival, independent of stage at diagnosis, age, or race/ethnicity (Keegan et al., 2009). These findings suggest that long-term disease management, which is central to FL given its indolent and relapsing course, may be particularly sensitive to inequities in healthcare access, continuity of follow-up, and quality of supportive care. Additional national data indicate that rural and non-metropolitan patients with FL have poorer overall survival compared with metropolitan patients, a disparity largely mediated by differences in insurance coverage, regional income levels, and treatment at lower-resource community facilities rather than academic centers (Ritter et al., 2020).

Geographic and environmental contexts further contribute to inequities in FL incidence and outcomes. National SEER analyses demonstrate that FL incidence varies by race/ethnicity and socioeconomic context, with lower incidence observed among non-Hispanic Black and Hispanic populations, potentially reflecting underdiagnosis or differential exposure to healthcare systems rather than true biologic protection (Blansky et al., 2020). While urban–rural differences in FL incidence are less pronounced than for other lymphoma subtypes, patients from non-metropolitan and rural areas are more likely to have lower socioeconomic status and limited access to specialized diagnostic services, including advanced imaging used for staging and response assessment (Blansky et al., 2020; Ritter et al., 2020). These data underscore the importance of equitable access to recommended imaging across care settings. Consistent application of evidence-based imaging can help mitigate disparities by supporting accurate staging, appropriate surveillance, and timely detection of transformation or progression, thereby reducing downstream inequities in outcomes for patients with follicular lymphoma.

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Marginal Zone Lymphomas (ONC-27.4)

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Criteria

- MALT lymphomas in any location and primary cutaneous marginal zone lymphoma should also be imaged according to these guidelines.
- Splenic Marginal Zone Lymphoma is diagnosed with splenomegaly, peripheral blood flow cytometry and bone marrow biopsy. Splenectomy is diagnostic and therapeutic. PET scan is not routinely considered medically necessary prior to splenectomy.

Indication	Medically Necessary Imaging Study
Initial staging/diagnosis of marginal zone lymphomas	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
EITHER of the following in individuals with marginal zone lymphomas: • If radiation therapy is being considered for stage I or II disease • If systemic therapy is planned	• PET/CT (CPT® 78815 or CPT® 78816)
Treatment response in individuals with marginal zone lymphomas	• CT with contrast of previously involved area(s) every 2 cycles of therapy
End of therapy evaluation in individuals with marginal zone lymphomas	ONE of the following: • CT with contrast of previously involved area(s) • PET/CT (CPT® 78815 or CPT® 78816)

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Indication	Medically Necessary Imaging Study
Suspected recurrence in individuals with marginal zone lymphomas	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s)
Suspected recurrence in individuals with marginal zone lymphomas and ANY of the following: • Symptoms of end organ dysfunction • Clinically significant or progressive cytopenias • Bulky disease (single mass of 7cm or greater or 3 or more nodal sites 3cm in diameter) • Steady or rapid progression	In addition to the CT imaging above: • PET/CT (CPT® 78815 or CPT® 78816)
Surveillance of all stages of nodal marginal zone lymphoma for any of the following: • After completion of active treatment • On maintenance treatment • Observation without any treatment	Every 6 months for two years, then annually: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s)

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Indication	Medically Necessary Imaging Study
Surveillance of all stages of extranodal marginal zone lymphoma	Advanced imaging is not routinely considered medically necessary for surveillance of asymptomatic individuals

Background and Supporting Information

Marginal zone lymphomas (MZL) are a heterogeneous group of indolent B-cell lymphomas that include extranodal marginal zone lymphoma (MALT lymphoma), splenic marginal zone lymphoma (SMZL), and nodal marginal zone lymphoma (NMZL). These entities differ in clinical presentation, typical sites of involvement, and patterns of dissemination, with extranodal disease often arising in mucosal tissues such as the stomach, ocular adnexa, lung, and salivary glands, while SMZL typically involves the spleen, bone marrow, and peripheral blood (Zucca et al., 2020).

Diagnosis integrates clinical findings, laboratory evaluation, bone marrow assessment, and histopathology, often supported by imaging for disease extent. The clinical course of MZL is generally indolent, with many patients presenting with localized disease (particularly extranodal MZL) or slowly progressive disseminated disease (especially nodal and splenic subtypes). Disease progression and treatment decisions are guided by clinical symptoms, organ involvement, cytopenias, and tumor burden rather than imaging alone (Zucca et al., 2020; NCCN, 2026).

Evidence Discussion

The recommendation for CT chest, abdomen, and pelvis with contrast for initial staging is supported by guideline-based evidence that cross-sectional imaging is essential for determining the extent of nodal and extranodal disease. CT provides reliable anatomic assessment across all MZL subtypes and remains the standard staging modality. PET/CT has a more limited role at diagnosis because FDG avidity is variable, particularly in extranodal marginal zone lymphoma, where only approximately 50%–75% of tumors demonstrate significant uptake, limiting its sensitivity and consistency in staging (Zucca et al., 2020; Barrington et al., 2014).

Selective use of PET/CT when systemic therapy is planned or when radiation therapy is considered for localized disease is supported by its ability to identify occult disease sites and establish a metabolic baseline for response assessment. In localized disease, PET/CT may help exclude disseminated involvement prior to definitive local therapy such as radiotherapy. In patients undergoing systemic therapy, baseline PET/CT provides a reference for evaluating treatment response and identifying patients who may require therapy intensification (Barrington et al., 2014; NCCN, 2026).

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For treatment response, the recommendation for serial CT imaging every 2 cycles reflects the lack of clear evidence supporting routine interim PET/CT in MZL. Current data indicate that PET/CT does not have a well-established role in interim restaging due to variable FDG avidity and uncertain prognostic value. At the end of therapy, however, PET/CT may provide incremental value in identifying residual metabolically active disease and distinguishing viable lymphoma from post-treatment changes, which can guide the need for additional therapy and reduce risks of both under- and overtreatment (Zucca et al., 2020; Barrington et al., 2014).

Surveillance strategies are based on the indolent nature of MZL and the limited evidence supporting routine imaging in asymptomatic patients. Extranodal marginal zone lymphoma often remains localized with a low risk of systemic progression, and routine advanced imaging has not demonstrated a survival benefit in asymptomatic individuals. For nodal MZL, periodic CT imaging is supported due to a higher likelihood of disseminated disease and relapse within the first two years, aligning with observed relapse patterns. Routine PET/CT surveillance is not recommended due to false-positive rates approaching 20%, which can result in unnecessary biopsies, additional imaging, increased cost, radiation exposure, and patient anxiety without improving outcomes (Lynch et al., 2014; NCCN, 2026; Zucca et al., 2020).

PET/CT is appropriately reserved for specific clinical scenarios such as suspected recurrence with high-risk features (e.g., cytopenias, bulky disease, organ dysfunction, or rapid progression) or suspected transformation, where increased FDG uptake can help identify aggressive disease and guide biopsy. This selective use balances the potential diagnostic benefit of PET/CT with its known harms, ensuring imaging is targeted to situations where it meaningfully impacts management (Barrington et al., 2014; Zucca et al., 2020).

Health Equity Considerations

Marginal zone lymphomas (MZL) represent a heterogeneous group of indolent lymphomas whose epidemiology, clinical presentation, and management are strongly influenced by geographic, infectious, and sociodemographic factors, creating important equity considerations. Extranodal MZL, particularly mucosa-associated lymphoid tissue (MALT) lymphoma, is closely linked to chronic infections and autoimmune conditions, including Helicobacter pylori, hepatitis C virus, and Sjögren syndrome, which occur with variable prevalence across populations and regions (Cheah et al., 2023; Noor et al., 2026). Geographic variation in infectious exposures contributes to differences in disease incidence and subtype distribution worldwide and may delay diagnosis in populations with limited access to specialty care or endoscopic, serologic, and pathologic testing needed to identify underlying etiologic drivers (Noor et al., 2026). Older age at diagnosis, comorbid autoimmune disease, and socioeconomic barriers to longitudinal surveillance are common in MZL and may compound disparities in

outcomes, particularly given the prolonged natural history and reliance on observation or response-adapted treatment strategies (Cheah et al., 2023).

Equitable access to appropriate imaging is a critical component of MZL care, as staging and response assessment differ by subtype and anatomic site. While PET/CT is not uniformly recommended across all MZL presentations, it plays an important role in selected cases to confirm disease extent, evaluate treatment response, and detect histologic transformation, which is associated with worse prognosis (Noor et al., 2026). Patients in rural or resource-limited settings may experience reduced access to PET/CT, site-specific imaging (e.g., MRI for ocular adnexal or CNS disease), or endoscopic surveillance for gastric MALT lymphoma, potentially leading to under-staging or delayed recognition of progression (Cheah et al., 2023). Consistent, evidence-based application of imaging recommendations across practice settings is essential to mitigate disparities, support accurate risk stratification, and ensure timely intervention for patients with marginal zone lymphomas regardless of geography, socioeconomic status, or underlying etiologic factors.

Oncology Imaging Guidelines

Mantle Cell Lymphoma (ONC-27.5)

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Criteria

Indication	Medically Necessary Imaging Study
Initial staging/diagnosis of mantle cell lymphoma	ONE of the following: • CT Chest with contrast (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) OR • PET/CT (CPT® 78815 or CPT® 78816)
Treatment response in individuals with mantle cell lymphoma	• PET/CT (CPT® 78815 or CPT® 78816) or CT with contrast of previously involved area(s) every 2-4 cycles of therapy
End of therapy evaluation in individuals with mantle cell lymphoma	ONE of the following: • CT with contrast of previously involved area(s) • PET/CT (CPT® 78815 or CPT® 78816)
Suspected recurrence in individuals with mantle cell lymphoma	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s) • PET/CT can be considered in rare circumstances (e.g., bone involvement).
Surveillance for all stages of mantle cell lymphoma	Every 6 months for 2 years, and then annually: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s)

Background and Supporting Information

Mantle cell lymphoma (MCL) is a mature B-cell non-Hodgkin lymphoma characterized by a heterogeneous disease course ranging from indolent to aggressive behavior. It

most commonly presents with advanced-stage disease involving lymph nodes, bone marrow, spleen, and extranodal sites, and carries a high risk of relapse, including late relapses occurring many years after initial remission (Guidot et al., 2018; NCCN, 2026).

Evidence Discussion

The recommendation to use either contrast-enhanced CT or PET/CT for initial staging is supported by guideline-based evidence demonstrating that both modalities provide comprehensive assessment of disease extent. PET/CT is generally preferred when systemic therapy is planned, as it improves detection of metabolically active disease sites and reduces the risk of underestimation of disease burden. This is particularly important in a disease such as MCL, which frequently presents with widespread involvement (Barrington et al., 2016; NCCN, 2026).

For interim treatment response, CT imaging every 2–4 cycles is supported by evidence showing that PET/CT has not consistently demonstrated improvement in outcomes when used for interim restaging. While PET/CT can detect early metabolic response, data do not support routine use for altering management during therapy. Therefore, CT remains the standard modality for serial anatomic assessment, reserving PET/CT for cases where disease is not well visualized on CT or when metabolic information is necessary (Barrington et al., 2016; NCCN, 2026).

At the end of therapy, PET/CT provides greater accuracy than CT alone for identifying residual metabolically active disease and distinguishing viable lymphoma from post-treatment changes. This distinction is clinically meaningful, as failure to achieve complete metabolic response may indicate the need for maintenance therapy or additional treatment. Thus, PET/CT at the end of therapy supports risk-adapted management and helps prevent both undertreatment and overtreatment (Barrington et al., 2016; Cheson et al., 2014).

For suspected recurrence, CT is supported for evaluation of disease burden, while PET/CT is reserved for select circumstances, such as evaluation of suspected bone involvement or when CT findings are inconclusive. This selective use reflects the balance between improved diagnostic sensitivity of PET/CT and its higher cost, radiation exposure, and potential for false-positive findings (Barrington et al., 2016).

Surveillance imaging recommendations reflect the limited clinical benefit of routine imaging in asymptomatic patients with MCL. Evidence demonstrates that detection of relapse through surveillance imaging does not improve overall survival compared with clinical detection. In a large retrospective cohort, relapse detected by surveillance imaging showed no survival advantage, and most relapses were identified through symptoms or clinical findings (Guidot et al., 2018). Additionally, PET/CT surveillance has a low positive predictive value of approximately 24%, leading to high rates of false positives and unnecessary downstream testing (Guidot et al., 2018). The harms of routine surveillance imaging include cumulative radiation exposure, increased

healthcare costs, patient anxiety, and unnecessary invasive procedures resulting from false-positive findings. Despite these limitations, CT-based surveillance remains supported due to ongoing uncertainty and variability in clinical practice, as well as the potential for late relapse in MCL. PET/CT surveillance is not recommended given its low predictive value and lack of demonstrated survival benefit, supporting a conservative and risk-adapted imaging approach aligned with NCCN guidance (Guidot et al., 2018; NCCN, 2026).

Health Equity Considerations

Mantle cell lymphoma (MCL) is an aggressive B-cell non-Hodgkin lymphoma that disproportionately affects older adults and is associated with complex, resource-intensive management strategies, including cytarabine-based induction, autologous stem cell transplantation (ASCT), maintenance therapy, and increasingly costly targeted agents. Population-based analyses demonstrate significant racial and socioeconomic disparities in outcomes for patients with MCL. In a large National Cancer Database study, Black patients experienced inferior overall survival compared with White and Hispanic patients, independent of stage, insurance status, and treatment setting, despite being more likely to receive care at academic or research centers (Shah et al, 2019). Black and Hispanic patients were also more likely to be uninsured or covered by Medicaid, reside in lower-income and lower-education areas, and were less likely to undergo ASCT, a treatment associated with improved survival in eligible patients, highlighting persistent structural barriers to optimal care delivery (Shah et al., 2019).

Equity considerations are closely tied to imaging access and utilization in MCL, where advanced imaging plays a central role in initial staging, response assessment, and detection of relapse or transformation. Differences in access to timely diagnostic imaging and longitudinal surveillance may contribute to delayed treatment initiation, incomplete staging, or missed opportunities for potentially life-prolonging therapies, particularly among patients treated outside high-resource settings. Treatment at academic centers has been independently associated with improved survival, likely reflecting greater access to specialized imaging, multidisciplinary expertise, and clinical trials (Shah et al., 2019). Standardized, evidence-based imaging recommendations are essential to reduce variability in care, support equitable staging and monitoring, and ensure that socioeconomic or racial factors do not limit access to appropriate diagnostic imaging for patients with mantle cell lymphoma.

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Burkitt's Lymphomas (ONC-27.6)

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Criteria

Indication	Medically Necessary Imaging Study
Initial staging/diagnosis of Burkitt's lymphomas	ANY or ALL of the following: • PET/CT (CPT® 78815 or CPT® 78816) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
Treatment response in individuals with Burkitt's lymphomas	• CT with contrast of previously involved area(s) every 2 cycles of therapy • PET/CT is not considered medically necessary for monitoring treatment response but can be considered in rare circumstances when CT did not show disease (e.g., bone).
End of therapy evaluation in individuals with Burkitt's lymphomas	ANY or ALL of the following: • PET/CT (CPT® 78815 or CPT® 78816) at the end of chemotherapy and again at the end of radiation • CT with contrast of previously involved area(s)
Suspected recurrence in individuals with Burkitt's lymphomas	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s) • PET/CT can be considered in rare circumstances (e.g., bone involvement).
Surveillance in individuals with Burkitt's lymphomas	Every 6 months for 2 years after completion of treatment: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)

Background and Supporting Information

Burkitt lymphoma is an aggressive, rapidly proliferating B-cell non-Hodgkin lymphoma characterized by high tumor growth fraction and frequent extranodal involvement,

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particularly in the abdomen, bone marrow, and central nervous system. Due to its rapid doubling time and potential for life-threatening complications such as tumor lysis syndrome, accurate and rapid staging is essential to guide urgent treatment decisions. Imaging plays a critical role in defining disease extent, including nodal bulk, visceral involvement, and anatomic relationships relevant to both therapy planning and emergent management (Cheson et al., 2014; NCCN, 2026).

Evidence Discussion

The recommendation to use both contrast-enhanced CT and PET/CT for initial staging is supported by evidence demonstrating complementary roles of anatomic and functional imaging in aggressive lymphomas. CT is essential for defining the size, distribution, and anatomic relationships of nodal and extranodal disease, including abdominal viscera and Waldeyer's ring involvement, all of which influence treatment planning and urgent management. PET/CT provides baseline metabolic characterization of disease, which is particularly important in Burkitt lymphoma due to its high FDG avidity and the central role of metabolic response in assessing treatment efficacy (Cheson et al., 2014; NCCN, 2026).

For treatment response during therapy, CT imaging every two cycles is supported by the principle that complete response should not be defined until completion of the full treatment regimen. Interim PET/CT has not been shown to reliably alter outcomes in aggressive lymphomas and may lead to premature interpretation of response. Therefore, CT is preferred for serial assessment of tumor burden during therapy, reserving PET/CT for select cases in which disease is not well visualized on CT, such as osseous involvement (Cheson et al., 2014; NCCN, 2026).

At the end of therapy, PET/CT is medically necessary because metabolic response provides critical prognostic and management information. Evidence demonstrates that FDG avidity distinguishes residual viable lymphoma from post-treatment fibrosis or necrosis more accurately than CT alone. Lack of complete metabolic response may indicate the need for additional therapy, such as treatment intensification or local therapy, while complete metabolic response supports treatment completion. This reinforces the combined use of PET/CT and CT at the end of therapy for comprehensive assessment (Cheson et al., 2014; NCCN, 2026).

For surveillance, the recommendations reflect the aggressive biology of Burkitt lymphoma and the limited benefit of routine imaging. Clinical relapse typically presents with rapid symptom development, and available evidence suggests that recurrence is frequently identified through clinical evaluation rather than imaging. Routine PET/CT surveillance is discouraged due to high false-positive rates, unnecessary radiation exposure, increased costs, and lack of demonstrated survival benefit. CT-based surveillance every 6 months for 2 years aligns with guideline-supported practice, recognizing that relapse beyond this timeframe is rare and that continued imaging in

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asymptomatic individuals has not been shown to improve outcomes (Cheson et al., 2014; NCCN, 2026).

Health Equity Considerations

Burkitt lymphoma (BL) demonstrates pronounced global, regional, and sociodemographic disparities that have important implications for diagnosis, staging, and outcomes. Analyses of the Global Burden of Disease 2021 data show that BL incidence and prevalence are increasingly concentrated in high sociodemographic index (SDI) countries, while mortality rates and disability-adjusted life years (DALYs) remain disproportionately higher in low-SDI regions, particularly in sub-Saharan Africa (Dou et al., 2025; Wang et al., 2024; Zhou et al., 2026). These patterns reflect differences in underlying risk factors (e.g., Epstein–Barr virus, malaria, HIV), age and sex distributions, and critically, access to diagnostic and treatment resources. Children aged 0–14 years and adults over 65 years bear the highest burden globally, with consistently higher incidence, mortality, and DALYs among males, underscoring populations that may be especially vulnerable to delays in diagnosis and intervention in resource-limited settings (Dou et al., 2025; Zhou et al., 2026).

Inequities in health system capacity, including limited access to advanced imaging, pathology, and molecular diagnostics, are central drivers of survival disparities in BL. In low-SDI regions, high mortality despite stable or declining incidence suggests underdiagnosis, advanced stage at presentation, and restricted access to timely imaging for accurate staging and response assessment (Wang et al., 2024; Zhou et al., 2026). Conversely, rising incidence in high-SDI countries is partly attributed to improved diagnostic precision and broader imaging utilization, highlighting how access can influence apparent disease burden (Dou et al., 2025; Wang et al., 2024). Standardized, evidence-based imaging recommendations are essential to mitigate these disparities by supporting timely diagnosis, consistent staging, and equitable monitoring across care settings, ensuring that differences in socioeconomic status or geographic location do not limit access to appropriate imaging in patients with Burkitt lymphoma.

Oncology Imaging Guidelines

Lymphoblastic Lymphomas (ONC-27.7)

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- Individuals with lymphoblastic lymphoma (even those with bulky nodal disease) are treated using the leukemia treatment plan appropriate to the cell type (B or T cell). Imaging indications in adult individuals are identical to those for pediatric individuals. See: **Acute Lymphoblastic Leukemia (ALL) (PEDONC-3.2)** in the Pediatric and Special Populations Oncology Imaging Guidelines.

Oncology Imaging Guidelines

T Cell Lymphomas (ONC-27.8)

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Criteria

- Includes Peripheral T-Cell Lymphomas, Mycosis Fungoides/Sézary Syndrome, Anaplastic Large Cell Lymphoma (ALCL) including breast implant-associated ALCL, Angioimmunoblastic lymphoma, and Primary Cutaneous CD30+T Cell Lymphoproliferative Disorders

Indication	Medically Necessary Imaging Study
Initial staging/diagnosis of T cell lymphomas	ANY or ALL of the following: • PET/CT (CPT® 78815 or CPT® 78816) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
T-cell lymphoma of nasal cavity, oropharynx, or nasopharynx	In addition to the imaging above: • MRI Orbits, Face, and Neck without and with contrast (CPT® 70543)
Breast implant-associated ALCL	In addition to the above initial staging studies: • Ultrasound Breast (CPT® 76641 or CPT® 76642) ◦ MRI Breast (CPT® 77049) for evaluation of inconclusive ultrasound findings
Treatment response in individuals with T cell lymphomas	Any ONE of the following after 3-4 cycles: • PET/CT (CPT® 78815 or 78816) or • CT Chest with contrast (CPT® 71260), and • CT Abdomen and Pelvis with contrast (CPT® 74177) and • CT with contrast of previously involved area(s)

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Indication	Medically Necessary Imaging Study
End of therapy evaluation in individuals with T cell lymphomas	Any ONE of the following at the end of chemotherapy and again at the end of radiation therapy: • PET/CT (CPT® 78815 or CPT® 78816) or • CT Chest with contrast (CPT® 71260), and • CT Abdomen and Pelvis with contrast (CPT® 74177), and • CT with contrast of previously involved area(s)
Suspected recurrence in individuals with T cell lymphomas	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s) • PET/CT can be considered in rare circumstances (e.g., bone involvement).
Surveillance, all stages of T cell lymphomas	Every 6 months for 2 years, then annually for 5 years: • CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and CT of previously involved areas ◦ PET/CT (CPT® 78815 or CPT® 78816) is considered medically necessary instead of CT for individuals with a history of extranodal disease that was not adequately imaged by conventional imaging

Background and Supporting Information

T-cell lymphomas represent a heterogeneous group of aggressive and indolent non-Hodgkin lymphomas that include peripheral T-cell lymphomas (PTCL), cutaneous T-cell lymphomas, anaplastic large cell lymphoma (ALCL), angioimmunoblastic T-cell lymphoma, and extranodal NK/T-cell lymphomas. These diseases frequently present with advanced-stage involvement and have a high propensity for extranodal disease, including the skin, gastrointestinal tract, liver, bone marrow, and nasopharyngeal structures (NCCN, 2026).

Evidence Discussion

The recommendation for combined use of PET/CT and contrast-enhanced CT for initial staging is supported by evidence demonstrating the high frequency of extranodal

disease in T-cell lymphomas and the limitations of single-modality imaging. PET/CT improves sensitivity for detecting metabolically active nodal and extranodal disease, including noncontiguous lymph nodes and visceral involvement that may be missed on regional CT imaging alone. However, PET/CT may have limitations in defining anatomic detail, particularly in complex regions such as Waldeyer's ring or gastrointestinal involvement, supporting the complementary use of diagnostic contrast-enhanced CT to ensure accurate staging and avoid under- or over-treatment (Barrington et al., 2016; NCCN, 2026).

For treatment response, the recommendation to perform imaging after 3–4 cycles is supported by evidence that early imaging may lead to inaccurate assessment of treatment effect and inappropriate modification of therapy. Both PET/CT and CT are acceptable for response assessment, with modality selection guided by which imaging best demonstrated disease at baseline. PET/CT provides metabolic response data, while CT provides anatomic assessment, and either modality is sufficient when used consistently for comparison. Repeat imaging at standardized intervals improves reliability of response evaluation and supports appropriate continuation or modification of therapy (Barrington et al., 2016; NCCN, 2026).

At the end of therapy, the use of PET/CT or CT is supported by evidence that both modalities can evaluate residual disease, with PET/CT offering improved specificity for distinguishing viable tumor from post-treatment changes. Persistent PET-positive lesions may require biopsy confirmation prior to additional therapy due to the risk of false-positive findings, reinforcing the importance of integrating imaging results with clinical and pathologic data (Barrington et al., 2016; NCCN, 2026).

Surveillance imaging recommendations reflect the balance between early detection of relapse and the absence of demonstrated overall survival benefit. Evidence indicates that routine imaging does not clearly improve survival compared with clinical detection, although some data suggest improved progression-free survival with imaging-based detection of relapse. CT-based surveillance is supported at defined intervals to align with NCCN guidance, while PET/CT is generally not recommended due to false-positive rates approaching 20%, increased radiation exposure, cost, and risk of unnecessary invasive procedures. The selective use of PET/CT in surveillance for individuals with disease not well visualized on CT (e.g., extranodal involvement) is supported by its ability to detect metabolically active disease not captured by conventional imaging. However, its routine use is limited by lack of survival benefit and higher rates of incidental findings. Overall, the imaging criteria reflect a risk-adapted approach that prioritizes diagnostic accuracy during staging and response assessment while minimizing harm from overuse of advanced imaging during surveillance (Barrington et al., 2016; Lynch et al., 2014; NCCN, 2026).

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Health Equity Considerations

T-cell lymphomas (TCLs) exhibit substantial and persistent inequities in incidence, diagnosis, treatment, and outcomes that are closely linked to race, ethnicity, socioeconomic status, and health system factors. Population-based analyses consistently demonstrate worse overall survival for older adults, males, and racial and ethnic minority populations, with no meaningful improvement in survival over several decades despite therapeutic advances (Crozier et al., 2015). Cutaneous T-cell lymphoma (CTCL), in particular, shows marked racial and socioeconomic gradients in incidence, with higher rates among Black patients and individuals residing in higher-income census tracts, likely reflecting a combination of biological susceptibility, delayed diagnosis related to misclassification as benign skin conditions, and differential access to dermatologic subspecialty care (Wiese et al., 2023). These patterns highlight how structural inequities and diagnostic access influence both disease recognition and apparent disease burden across populations.

Social determinants of health play a critical role in outcomes for nodal peripheral T-cell lymphomas (PTCL), extending beyond traditional clinical prognostic factors. Recent large-scale analyses demonstrate that treatment at academic or NCI-designated cancer centers, insurance coverage, and educational attainment are among the strongest independent predictors of lymphoma-specific survival, with treatment at an academic center associated with nearly a 30% reduction in mortality risk (Mead et al., 2025). Patients from less-resourced communities are significantly less likely to receive care at specialized centers and therefore may have limited access to advanced imaging, multidisciplinary expertise, and clinical trials essential for optimal staging and response assessment. Standardized, evidence-based imaging recommendations support health equity by promoting timely diagnosis, accurate staging, and consistent disease monitoring across care settings, helping to mitigate disparities driven by geographic location, insurance status, and differential access to specialized oncology services in patients with T-cell lymphomas.

Oncology Imaging Guidelines

Post-Transplant Lymphoproliferative Disorders (ONC-27.9)

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v1.0.2027

Criteria

- This section applies to Monomorphic (B-cell type) post-transplant lymphoproliferative disorder (PTLD) and Polymorphic PTLD.
- For Hodgkin-lymphoma subtype of PTLD, see: **Hodgkin Lymphomas (ONC-28)** for imaging recommendations.

Indication	Medically Necessary Imaging Study
Initial staging/diagnosis of PTLD	ANY or ALL of the following: • PET/CT (CPT® 78815 or CPT® 78816) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
Treatment response in individuals with PTLD	ANY or ALL of the following after 4 weeks of reducing immunosuppression or every 2 cycles (6-8 weeks) of chemo/ immunotherapy: • CT Chest with contrast (CPT® 71260), and • CT Abdomen and Pelvis with contrast (CPT® 74177), and • CT with contrast of previously involved area(s)
End of therapy evaluation in individuals with PTLD	ANY one of the following at the end of treatment: • PET/CT (CPT® 78815 or CPT® 78816) or • CT Chest with contrast (CPT® 71260), and • CT Abdomen and Pelvis with contrast (CPT® 74177), and • CT with contrast of previously involved area(s)
Suspected recurrence in individuals with PTLD	• CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
Surveillance in individuals with PTLD	See disease-specific guideline

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Background and Supporting Information

Post-transplant lymphoproliferative disorders (PTLD) comprise a spectrum of lymphoid proliferations arising in the setting of immunosuppression following solid organ or hematopoietic stem cell transplantation. These disorders are strongly associated with impaired immune surveillance and Epstein-Barr virus (EBV) infection and may range from polymorphic proliferations to monomorphic lymphomas resembling aggressive non-Hodgkin lymphoma, often involving nodal and extranodal sites (Pan et al., 2021; NCI, 2025).

PTLD frequently presents with multisite and extranodal disease, including involvement of the gastrointestinal tract, liver, lungs, and central nervous system, reflecting the systemic nature of immune dysregulation in transplant recipients. Imaging plays an essential role in defining disease extent for staging and therapeutic planning, particularly in distinguishing localized from disseminated disease, which has implications for treatment selection including local versus systemic therapy (NCI, 2025; NCCN, 2026).

Initial management commonly involves reduction of immunosuppression (RIS), which may lead to regression of disease but carries risks such as allograft rejection and variable response rates, often necessitating additional therapy with rituximab or chemoimmunotherapy. Disease biology, tumor burden, and extent of involvement are important determinants of prognosis and guide management strategies, reinforcing the importance of accurate imaging-based staging and response assessment (Pan et al., 2021; NCI, 2025).

Evidence Discussion

The recommendation for combined use of PET/CT and contrast-enhanced CT for initial staging is supported by evidence demonstrating that PTLD frequently presents with extranodal and multisite disease that may not be fully detected with regional CT imaging alone. FDG PET/CT improves sensitivity for identifying metabolically active disease sites, while diagnostic CT provides detailed anatomic characterization necessary to differentiate bulky masses from noncontiguous nodal disease and to guide treatment planning. Accurate identification of disease extent is critical because localized disease may be treated with local therapy, whereas disseminated disease requires systemic treatment, and underestimation of disease burden may lead to undertreatment (Cheson et al., 2014; Barrington et al., 2014; NCCN, 2026).

For treatment response, the recommendation to use CT at defined intervals, including as early as 4 weeks after reduction of immunosuppression, is supported by the rapid clinical dynamics of PTLD. Evidence indicates that median time to failure of reduction of immunosuppression is relatively short, approximately 45 days, necessitating early reassessment to ensure timely escalation of therapy. CT provides reliable anatomic assessment for serial monitoring, while interim PET/CT is not required for directing changes in therapy due to lack of evidence supporting improved outcomes from PET-

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driven early intervention. Suspicious findings on CT should be confirmed with biopsy to avoid misclassification (Pan et al., 2021; NCI, 2025; Cheson et al., 2014).

At the end of therapy, PET/CT is supported to confirm complete metabolic response, which is important for determining treatment completion versus the need for further therapy. Functional imaging has greater specificity than CT for distinguishing viable lymphoma from residual fibrotic or necrotic tissue, reducing the risk of both overtreatment and undertreatment. When a complete metabolic response is achieved, additional diagnostic CT imaging does not provide incremental benefit, supporting the use of PET/CT as a standalone modality in this setting (Cheson et al., 2014; Barrington et al., 2014).

The recommendation against routine surveillance imaging is supported by evidence demonstrating no improvement in outcomes with imaging-based surveillance in PTLD. Surveillance imaging exposes individuals to cumulative radiation, increased healthcare costs, and a higher likelihood of false-positive findings that may lead to unnecessary biopsies and interventions. Instead, monitoring with clinical evaluation and EBV PCR is preferred, as PTLD recurrence is often detectable through clinical or laboratory changes. This approach minimizes harm while maintaining effective detection of clinically meaningful relapse (NCI, 2025; Pan et al., 2021).

Health Equity Considerations

Post-transplant lymphoproliferative disorders (PTLD) represent a serious and disproportionate malignancy risk among solid organ and hematopoietic stem-cell transplant recipients, reflecting inequities driven by immunosuppression intensity, Epstein–Barr virus (EBV) serostatus, transplant type, and access to long-term specialty care. Large registry and cohort studies demonstrate that PTLD incidence is markedly higher in transplant recipients than in immunocompetent populations, with risk varying substantially by organ transplanted, donor–recipient EBV mismatch, cumulative immunosuppression, and age, and with a bimodal distribution that includes both early and late presentations (Dierickx & Habermann, 2018). These patterns underscore the importance of equitable access to consistent, lifelong post-transplant monitoring, as delayed recognition, particularly in late-onset or EBV-negative disease, can worsen outcomes. Vulnerable populations may face additional barriers to timely evaluation, including fragmented follow-up across transplant and oncology systems, geographic distance from transplant centers, and limited access to advanced diagnostic imaging and subspecialty pathology review.

Data suggest that outcomes for PTLD have improved in the modern era with standardized treatment pathways and multidisciplinary management, yet these gains may not be uniformly realized across care settings (Katz-Greenberg et al., 2021). Contemporary series highlight the central role of reduction of immunosuppression, risk-adapted chemoimmunotherapy, and FDG-PET/CT for staging and response

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assessment, while also demonstrating variability in metabolic profiles and disease burden at presentation that can influence prognosis. Ensuring equitable access to guideline-concordant imaging, including PET/CT for accurate staging of extranodal and allograft involvement, is critical, as under-staging can lead to suboptimal therapy. Standardized imaging recommendations for PTLD help promote equitable care by supporting timely diagnosis, consistent disease assessment, and coordinated management across transplant and oncology services, thereby reducing disparities related to care fragmentation, resource availability, and variability in practice patterns (Dierickx & Habermann, 2018; Katz-Greenberg et al., 2021).

Oncology Imaging Guidelines

Waldenström Macroglobulinemia or Lymphoplasmacytic Lymphoma (ONC-27.10)

ON.NH.0027.10.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Initial staging/diagnosis of Waldenström Macroglobulinemia or Lymphoplasmacytic Lymphoma	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • PET/CT (CPT® 78815 or CPT® 78816)
Treatment response in individuals with Waldenström Macroglobulinemia or Lymphoplasmacytic Lymphoma	• CT with contrast of previously involved area(s) every 2 cycles of therapy
End of therapy evaluation in individuals with Waldenström Macroglobulinemia or Lymphoplasmacytic Lymphoma	• CT with contrast of previously involved area(s)
Suspected recurrence in individuals with Waldenström Macroglobulinemia or Lymphoplasmacytic Lymphoma	ANY or ALL of the following: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s)

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Indication	Medically Necessary Imaging Study
Surveillance in individuals with Waldenström Macroglobulinemia or Lymphoplasmacytic Lymphoma	No advanced imaging for surveillance
Individuals with Waldenström Macroglobulinemia or Lymphoplasmacytic Lymphoma with bony lesions	See: **Multiple Myeloma and Plasmacytomas (ONC-25)**

Background and Supporting Information

Waldenström macroglobulinemia (WM), also referred to as lymphoplasmacytic lymphoma (LPL), is a rare indolent B-cell malignancy characterized by bone marrow infiltration of lymphoplasmacytic cells and production of monoclonal immunoglobulin M (IgM) protein. Diagnosis requires both bone marrow involvement and the presence of IgM monoclonal gammopathy, and clinical manifestations are related to tumor burden, organ infiltration, or IgM-mediated effects such as hyperviscosity (Dimopoulos & Kastritis, 2019; Thomas et al., 2019).

The disease course is often indolent with prolonged asymptomatic phases, and treatment decisions are driven by symptoms, organ involvement, cytopenias, and IgM-related complications rather than imaging findings alone. Imaging is not required for diagnosis but may aid in identifying lymphadenopathy, organomegaly, and extranodal disease, contributing to assessment of tumor burden and clinical complications (Dimopoulos & Kastritis, 2019; Thomas et al., 2019).

Monitoring of WM/LPL is primarily based on laboratory parameters including IgM levels, serum proteins, and bone marrow involvement. Imaging findings may be variable, and disease burden may not correlate directly with imaging abnormalities, reflecting the biologic heterogeneity of bone marrow infiltration and paraprotein production (Banwait et al., 2011; Dimopoulos & Kastritis, 2019).

Evidence Discussion

The recommendation for contrast-enhanced CT of the chest, abdomen, and pelvis and/or PET/CT for initial staging is supported by NCCN, which considers both diagnostic CT and PET/CT acceptable for evaluation of disease extent in Waldenström

macroglobulinemia/LPL (NCCN, 2026). CT provides reliable anatomic assessment of lymphadenopathy and organomegaly, while PET/CT may improve detection of metabolically active disease and marrow involvement. Prospective data demonstrate that combined PET/CT detects disease in a higher proportion of patients than CT alone (83% vs. 69%), supporting its equivalency as an imaging option at diagnosis (Banwait et al., 2011; NCCN, 2026; Thomas et al., 2019).

For treatment response, NCCN supports serial contrast-enhanced CT imaging every 2 cycles and at the end of therapy to assess anatomic disease burden and prevent undertreatment (NCCN, 2026). This approach is reinforced by evidence showing that although PET/CT may demonstrate metabolic changes, response in WM/LPL is primarily defined by monoclonal IgM levels rather than imaging findings. Studies show no statistically significant correlation between FDG-PET response criteria and monoclonal protein response, limiting the utility of PET/CT for routine restaging (Banwait et al., 2011; Dimopoulos & Kastritis, 2019; NCCN, 2026). Accordingly, CT remains the preferred modality for interval response assessment.

At the end of therapy and in suspected recurrence, NCCN supports continued use of contrast-enhanced CT to evaluate previously involved areas and detect progression or recurrence (NCCN, 2026). CT provides consistent, reproducible anatomic assessment of nodal and extranodal disease, while PET/CT is not routinely recommended due to its inconsistent correlation with disease biology. Imaging findings must be interpreted alongside laboratory parameters, as tumor burden may not parallel IgM levels or marrow involvement, reducing the incremental value of PET/CT in these settings (Banwait et al., 2011; Dimopoulos & Kastritis, 2019; NCCN, 2026).

The recommendation against routine surveillance imaging is strongly supported by NCCN and clinical evidence demonstrating that WM/LPL is best monitored through laboratory parameters, including IgM levels, serum proteins, and blood counts (NCCN, 2026). Imaging has no established role in asymptomatic surveillance because it does not reliably reflect disease activity or improve outcomes. Additionally, unnecessary imaging introduces harms including radiation exposure, cost, and incidental findings without demonstrated clinical benefit. Clinical and laboratory monitoring therefore remain the standard approach for follow-up (Dimopoulos & Kastritis, 2019; Thomas et al., 2019; NCCN, 2026).

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Hodgkin Lymphoma (ONC-28)

Guideline Page

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Oncology Imaging Guidelines

Hodgkin Lymphoma – General Considerations (ONC-28.1)

ON.HL.0028.1.A
v1.0.2027

Criteria

- Individuals with AIDS-related lymphoma should be imaged according to the primary lymphoma histology.
- The **Deauville Criteria** are internationally accepted criteria, which utilize a 5-point scoring system for the FDG avidity of a Hodgkin's lymphoma or Non-Hodgkin's lymphoma tumor mass as seen on FDG PET.
  - Score 1: No uptake above the background
  - Score 2: Uptake ≤mediastinum
  - Score 3: Uptake >mediastinum but ≤liver
  - Score 4: Uptake moderately increased compared to the liver at any site
  - Score 5: Uptake markedly increased compared to the liver at any site
  - Score X: New areas of uptake unlikely to be related to lymphoma

Indication	Medically Necessary Imaging Study
• Biopsy proven lymphoma, or • Suspected lymphoma and any one of the following: ◦ Bulky lymphadenopathy (LN mass greater than 10cm) ◦ Hepatomegaly ◦ Splenomegaly ◦ B symptom: Unexplained fever, drenching night sweats, unintended weight loss greater than 10% total body weight	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast ◦ MRI without and with contrast for individuals who cannot tolerate CT contrast due to allergy or impaired renal function
Signs or symptoms of Hodgkin lymphoma involving the neck	• CT Neck with contrast (CPT® 70491)
Signs or symptoms suggesting CNS involvement with lymphoma	• MRI Brain without and with contrast (CPT® 70553) • See: **CNS Lymphoma (also known as Microglioma) (ONC-2.7)**

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Indication	Medically Necessary Imaging Study
Known or suspected bone involvement with lymphoma	• MRI without and with contrast of symptomatic or previously involved bony areas ◦ Bone scan is inferior to MRI for evaluation of known or suspected bone involvement with lymphoma
Determine a more favorable site for biopsy when a relatively inaccessible site is contemplated in individuals with Hodgkin lymphoma	• PET/CT (CPT® 78815 or CPT® 78816) ◦ PET/CT is not considered medically necessary for all other indications prior to histological confirmation of lymphoma
CAR-T cell therapy in individuals with Hodgkin lymphoma	Once before treatment and once 30-60 days after completion of treatment: • PET/CT (CPT® 78815 or CPT® 78816) Once at baseline prior to therapy if required by institutional protocol, and at any time for any new neurological symptoms: • MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Hodgkin lymphoma (HL) is a malignant lymphoid neoplasm characterized by the presence of Reed-Sternberg cells, with two primary subtypes: classic Hodgkin lymphoma (CHL) and nodular lymphocyte-predominant Hodgkin lymphoma (NLPHL). Diagnosis is based on tissue biopsy, and clinical presentation commonly includes lymphadenopathy, hepatosplenomegaly, and systemic "B symptoms" such as fever, night sweats, and weight loss, which are key indicators of disease burden and prognosis according to major clinical guidelines (NCCN, 2026).

Risk stratification and staging are central to management and are determined by factors including disease stage, presence of bulky disease (e.g., mediastinal mass or nodal conglomerate >10cm), number of nodal regions involved, and laboratory features such as erythrocyte sedimentation rate (ESR). These parameters distinguish favorable, unfavorable, and advanced disease and guide treatment planning and imaging utilization (NCCN, 2026).

Evidence Discussion

The imaging criteria recommending contrast-enhanced CT of the chest, abdomen, and pelvis for suspected or biopsy-proven lymphoma are supported by NCCN guidelines, which emphasize comprehensive anatomic evaluation during initial workup. CT imaging

reliably identifies lymphadenopathy, hepatosplenomegaly, and extranodal disease, all of which are critical for accurate staging and risk stratification. These anatomic findings directly influence classification into favorable, unfavorable, or advanced disease categories, thereby guiding treatment selection (NCCN, 2026).

Targeted imaging such as CT of the neck, MRI of the brain, and MRI of bone for specific clinical indications is supported by evidence that Hodgkin lymphoma can involve extranodal sites, including the central nervous system and osseous structures, although less commonly. MRI is preferred for evaluation of CNS and bone involvement due to superior soft-tissue contrast and sensitivity compared to other modalities, while bone scintigraphy has been shown to be inferior for detecting osseous disease, supporting the preference for MRI in these scenarios (NCCN, 2026).

The addition of PET/CT for selected indications, including determining a more favorable biopsy site, is supported by its superior ability to detect metabolically active disease and identify occult sites of involvement. NCCN guidelines recommend FDG-PET/CT as part of initial staging and response assessment, particularly because it may reveal disease sites not apparent on CT, thereby reducing the risk of sampling error and improving diagnostic yield when biopsy of less accessible lesions is being considered. The use of FDG-PET/CT with Deauville scoring provides a standardized and reproducible framework for response assessment, supporting treatment adaptation while minimizing unnecessary changes in therapy. NCCN emphasizes that PET findings must be interpreted carefully, as both false-positive and false-negative results can occur if imaging protocols are not standardized or if uptake is related to non-malignant causes such as inflammation. This highlights the importance of integrating imaging findings with clinical and pathologic data to avoid inappropriate management decisions. Restrictions on the use of PET/CT prior to histologic confirmation and in non-indicated scenarios are supported by the potential harms of overutilization, including false-positive findings, unnecessary procedures, and increased healthcare costs. NCCN explicitly notes that imaging results should not supersede biopsy confirmation and that PET/CT interpretation requires standardized acquisition and expert review to prevent misclassification of disease. These considerations balance diagnostic benefit with the risks of over-imaging, supporting selective and guideline-driven use of advanced imaging modalities (NCCN, 2026).

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Classical Hodgkin Lymphoma (ONC-28.2)

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Criteria

- This section applies to nodular sclerosis, mixed cellularity, lymphocyte-depleted and lymphocyte-rich subtypes of Hodgkin lymphoma.
- Pregnancy-specific considerations: US Abdomen (CPT® 76700) or MRI Abdomen without contrast (CPT® 74181) and MRI Pelvis without contrast (CPT® 72195) are considered medically necessary in lieu of PET/CT or CT imaging.
  - MRI Abdomen and MRI Pelvis may be performed after US Abdomen if staging is unclear on US.

Indication	Medically Necessary Imaging Study
Initial staging/diagnosis of classical Hodgkin lymphoma	ANY or ALL of the following: • PET/CT (CPT® 78815 or CPT® 78816) • CT Neck with contrast (CPT® 70491) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
Prior to initiation of therapy if one month or more has passed since previous PET/CT was performed in individuals with classical Hodgkin lymphoma	• PET/CT (CPT® 78815 or CPT® 78816)
Treatment response in individuals with classical Hodgkin lymphoma	• PET/CT (CPT® 78815 or CPT® 78816) as frequently as every 2 cycles
End of chemotherapy and/or radiation therapy evaluation in individuals with classical Hodgkin lymphoma	• PET/CT (CPT® 78815 or CPT® 78816) at the end of chemotherapy and again at the end of radiation (at least 12 weeks after completion of radiation therapy)

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Indication	Medically Necessary Imaging Study
Suspected or biopsy proven recurrence in individuals with classical Hodgkin lymphoma	ANY or ALL of the following: • CT Neck with contrast (CPT® 70491) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s) • PET/CT (CPT® 78815 or CPT® 78816) if suspected recurrence ≥3 months after completion of therapy
Surveillance in individuals with a history of recurrent classical Hodgkin lymphoma	ANY or ALL of the following, every 6 months for 2 years after completion of therapy: • CT Neck with contrast (CPT® 70491) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s) In addition to the above studies: • A single follow-up PET/CT at three months if end of therapy PET/CT shows Deauville 4 or 5 FDG avidity
Surveillance in individuals with classical Hodgkin lymphoma in first remission (i.e., no history of recurrence)	• A single follow-up PET/CT at three months if end of therapy PET/CT shows Deauville 4 or 5 FDG avidity • Routine surveillance imaging is otherwise not considered medically necessary for asymptomatic individuals

Background and Supporting Information

Classical Hodgkin lymphoma (CHL) is a malignant lymphoid neoplasm defined by the presence of Reed-Sternberg cells and includes nodular sclerosis, mixed cellularity, lymphocyte-depleted, and lymphocyte-rich subtypes. Clinical presentation commonly includes lymphadenopathy, hepatosplenomegaly, and systemic "B symptoms," which are incorporated into staging and risk stratification systems that guide management (NCCN, 2026).

Staging and risk classification are based on extent of nodal involvement, presence of bulky disease (e.g., mediastinal mass or nodal conglomerate >10cm), extranodal disease, and laboratory parameters such as erythrocyte sedimentation rate. These factors distinguish favorable, unfavorable, and advanced disease categories and influence imaging strategies and treatment planning (NCCN, 2026).

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Evidence Discussion

The recommendation for FDG-PET/CT and contrast-enhanced CT of the neck, chest, abdomen, and pelvis for initial staging is strongly supported by NCCN guidance, which endorses integrated FDG-PET/CT as a standard component of the diagnostic workup for Hodgkin lymphoma. PET/CT provides whole-body metabolic assessment and can detect both nodal and extranodal disease, while contrast-enhanced CT offers detailed anatomic characterization, including identification of bulky disease and organ involvement. The combination of these modalities improves staging accuracy and informs risk stratification, which directly impacts treatment selection (NCCN, 2026).

The recommendation to repeat PET/CT prior to therapy if more than one month has elapsed and to use PET/CT for treatment response assessment every two cycles is supported by NCCN principles indicating that staging PET/CT should be performed within one month of therapy initiation and that interim PET imaging can guide response-adapted treatment strategies. PET-based response assessment using the Deauville scoring system allows early identification of treatment response or refractory disease, supporting optimization of therapy while minimizing both undertreatment and overtreatment (NCCN, 2026).

End-of-therapy PET/CT evaluation is supported by evidence demonstrating that metabolic response is predictive of treatment outcomes. NCCN recommends PET/CT at completion of chemotherapy and after radiation therapy, with careful timing to reduce false-positive findings related to post-treatment inflammation. The requirement for at least a 12-week interval after radiation therapy reflects the need to minimize inflammatory FDG uptake that could otherwise lead to misinterpretation and unnecessary interventions (NCCN, 2026).

For suspected or biopsy-proven recurrence, the use of CT and PET/CT imaging is supported by NCCN guidance recommending imaging for evaluation of relapse when clinically indicated. PET/CT is particularly useful for detecting metabolically active recurrent disease but should generally be performed at least 3 months after completion of therapy to avoid false-positive results. This approach balances sensitivity for recurrence detection with the risk of misclassification due to treatment-related changes (NCCN, 2026).

The recommendation for surveillance CT imaging every 6 months for 2 years is consistent with NCCN acknowledgment that imaging may be used selectively in follow-up when clinically indicated, though routine surveillance imaging, particularly PET/CT, is discouraged due to the risk of false-positive findings and lack of evidence demonstrating improved outcomes. NCCN specifically cautions against routine surveillance PET/CT and emphasizes that imaging findings should not be used in isolation without clinical or pathologic correlation. This reflects the balance between early detection of relapse and avoidance of unnecessary radiation exposure, cost, and downstream procedures (NCCN, 2026).

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Health Equity Considerations

Classical Hodgkin lymphoma (cHL) is a highly curable malignancy, yet substantial and persistent disparities in outcomes remain across socioeconomic and demographic groups. Population-based data demonstrate that patients from lower neighborhood socioeconomic status (SES) groups experience significantly worse overall and disease-specific survival compared with patients from higher SES neighborhoods, regardless of disease stage or age at diagnosis (Keegan et al., 2010). In addition, racial and ethnic disparities are evident, with Black and Hispanic patients experiencing higher mortality than non-Hispanic White patients even after adjustment for neighborhood SES, suggesting that structural barriers beyond stage at presentation influence outcomes (Keegan et al., 2010; Murthy et al., 2019). These inequities may reflect differences in access to timely diagnosis, high-quality staging, optimal multimodality treatment, survivorship care, and long-term surveillance, particularly in healthcare settings with limited resources.

More contemporary analyses indicate that overall survival for advanced-stage cHL has improved over time with modern treatment strategies; however, disparities by race, marital status, age, and socioeconomic factors persist at the population level (Murthy et al., 2019). Minority race and lack of social support have been independently associated with higher mortality, underscoring the role of nonbiological determinants such as access to subspecialty oncology care, adherence to therapy, and continuity of follow-up. Imaging plays a critical role in accurate staging, treatment response assessment, and detection of relapse or transformation, and disparities in access to advanced imaging modalities such as PET/CT may further exacerbate inequities in outcomes. Standardized, evidence-based imaging recommendations for cHL aim to promote equitable diagnostic evaluation and disease monitoring across diverse patient populations, helping to reduce variation in care and support optimal outcomes independent of socioeconomic or demographic factors (Keegan et al., 2010; Murthy et al., 2019).

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Nodular Lymphocyte – Predominant Hodgkin Lymphoma (ONC-28.3)

ON.HL.0028.3.A
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Criteria

Indication	Medically Necessary Imaging Study
Initial staging/diagnosis of nodular lymphocyte-predominant Hodgkin lymphoma	ANY or ALL of the following: • PET/CT (CPT® 78815 or CPT® 78816) • CT Neck with contrast (CPT® 70491) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177)
Treatment response in individuals with nodular lymphocyte-predominant Hodgkin lymphoma	• PET/CT (CPT® 78815 or CPT® 78816) as frequently as every 2 cycles
End of chemotherapy and/or radiation therapy evaluation in individuals with nodular lymphocyte-predominant Hodgkin lymphoma	• PET/CT (CPT® 78815 or CPT® 78816) at the end of chemotherapy and again at the end of radiation (at least 12 weeks after completion of radiation therapy)
Suspected recurrence in individuals with nodular lymphocyte-predominant Hodgkin lymphoma	ANY or ALL of the following: • CT Neck with contrast (CPT® 70491) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s)
Biopsy proven recurrence in individuals with nodular lymphocyte-predominant Hodgkin lymphoma	• PET/CT (CPT® 78815 or CPT® 78816)

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Indication	Medically Necessary Imaging Study
Suspected transformation (Richter's) from a low-grade lymphoma to a more aggressive type based on one or more of the following: • New B symptoms • Rapidly growing lymph nodes • Extranodal disease develops • Significant recent rise in LDH above normal range	• PET/CT (CPT® 78815 or CPT® 78816)
Surveillance in individuals with nodular lymphocyte-predominant Hodgkin lymphoma	ANY or ALL of the following every 6 months for 2 years after completion of therapy: • CT Neck with contrast (CPT® 70491) • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis with contrast (CPT® 74177) • CT with contrast of previously involved area(s) In addition to the above studies: • A single follow-up PET/CT at three months if end of therapy PET/CT shows Deauville 4 or 5 FDG avidity

Background and Supporting Information

Nodular lymphocyte-predominant Hodgkin lymphoma (NLPHL) is a distinct subtype of Hodgkin lymphoma characterized by an indolent clinical course, frequent peripheral lymphadenopathy, and a tendency for late relapses. Similar to other Hodgkin lymphoma subtypes, disease presentation and prognosis are influenced by stage, tumor burden, and clinical risk factors, and accurate staging is essential for treatment selection and monitoring (Borchmann et al., 2021).

Evidence Discussion

The recommendation for PET/CT in initial staging and response assessment is supported by multiple sources demonstrating its high sensitivity for detecting metabolically active Hodgkin lymphoma and its superiority over anatomic imaging alone. PET/CT enables accurate identification of nodal and extranodal disease, improves

staging accuracy, and frequently upstages disease compared with CT alone, directly influencing treatment stratification and preventing undertreatment (Cheson et al., 2014; Borchmann et al., 2021). Additionally, PET-based response criteria provide standardized assessment of metabolic activity, allowing differentiation between residual viable tumor and fibrosis, which cannot be reliably achieved with CT alone (Cheson et al., 2014).

The use of PET/CT at defined intervals during treatment is supported by evidence showing that interim PET response is highly prognostic and central to response-adapted therapy. Prospective randomized data demonstrate that PET-guided approaches can safely guide treatment de-escalation (e.g., omission of radiotherapy) in patients with favorable metabolic response without compromising progression-free survival, while identifying high-risk patients who may require intensified therapy (Borchmann et al., 2021). This supports the guideline allowance for PET/CT as frequently as every 2 cycles to guide ongoing treatment and confirm metabolic response.

The recommendation to delay PET/CT following radiation therapy is supported by evidence demonstrating significant false-positive rates shortly after treatment due to inflammatory uptake. False-positive findings can lead to unnecessary biopsies, additional imaging, and treatment escalation. Studies report substantial rates of false-positive PET findings and unnecessary invasive procedures when imaging is performed too soon after therapy, reinforcing the requirement for appropriate timing to minimize harm (Picardi et al., 2014).

For evaluation of recurrence, the combined use of CT and PET/CT is supported by the complementary strengths of these modalities. PET/CT is highly sensitive for detecting metabolically active relapse, while CT provides anatomic localization. However, evidence also shows that PET/CT specificity is limited by false positives, particularly in mediastinal or inflammatory processes, resulting in unnecessary biopsies and procedures. This balance supports selective use of PET/CT, particularly ≥3 months after therapy, to improve diagnostic accuracy while minimizing harm (Picardi et al., 2014; Cheson et al., 2014).

Surveillance imaging recommendations reflect a balance between early relapse detection and potential harms of over-imaging. Large observational and multicenter data demonstrate that routine imaging surveillance does not improve overall survival or progression-free survival compared with clinical follow-up. Relapses are frequently detected through clinical symptoms or examination rather than imaging, and routine imaging is associated with increased radiation exposure, cost, and high false-positive rates leading to unnecessary interventions (Bastos Oreiro et al., 2021; Picardi et al., 2014). Although some guideline frameworks (e.g., NCCN) continue to allow limited CT surveillance, the overall evidence supports minimizing imaging and prioritizing clinical monitoring to reduce harm without compromising outcomes.

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Health Equity Considerations

Nodular lymphocyte-predominant Hodgkin lymphoma (NLPHL) is a rare, indolent lymphoma with excellent long-term survival for most patients; however, its rarity and heterogeneity may contribute to inequities in diagnosis, staging, and longitudinal management. Accurate diagnosis requires excisional lymph node biopsy and expert hematopathology review to distinguish NLPHL from classical Hodgkin lymphoma and from biologically related entities such as T-cell/histiocyte-rich large B-cell lymphoma, particularly in patients with variant immunoarchitectural patterns or suspected transformation (Salvaris et al., 2024; Ansell, 2024). Limited access to subspecialty pathology, molecular classification expertise, and advanced imaging may increase the risk of misclassification or delayed diagnosis, potentially resulting in overtreatment, undertreatment, or missed transformation. These challenges may disproportionately affect patients treated in resource-limited settings or outside of academic centers.

Imaging equity is particularly important in NLPHL, as positron emission tomography/computed tomography (PET/CT) plays a central role in accurate staging, assessment of bulky or extranodal disease, and evaluation for relapse or transformation, while also reducing the need for invasive procedures such as routine bone marrow biopsy (Salvaris et al., 2024; Ansell, 2024). Risk-adapted strategies, including active surveillance, de-escalated radiotherapy, and PET-guided treatment approaches, aim to minimize long-term treatment-related toxicity in a population with excellent survival, but require consistent access to high-quality imaging and multidisciplinary expertise (Ansell, 2024; Salvaris et al., 2024). Standardized evidence-based imaging recommendations for NLPHL support equitable application of modern staging and surveillance practices, helping to reduce variability in care and ensuring that patients across diverse care settings can benefit from toxicity-sparing, risk-appropriate management strategies.

Oncology Imaging Guidelines

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v1.0.2027

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Hematopoietic Stem Cell Transplantation (ONC-29)

Guideline Page

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General Criteria for Stem Cell Transplant (ONC-29.1)

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Pre-Transplant Imaging Criteria in Hematopoietic Stem Cell Transplantation (HSCT):

- Pre-transplant imaging in HSCT generally takes place within 30 days prior to transplant and involves a reassessment of the individual's disease status as well as infectious disease clearance.

Indication	Medically Necessary Imaging Study
Immediate pre-transplant period in HSCT	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) for ANY of the following: ◦ Any individual prior to undergoing allogeneic transplant ◦ New findings on chest x-ray ◦ New/worsening signs/symptoms of chest involvement • CT Sinus (CPT® 70486) for any clinical signs or symptoms or previous sinus disease • CT of other body areas is not considered medically necessary without clinical signs or symptoms of involvement • For individuals receiving CAR-T, if required by institutional protocol, baseline MRI Brain without and with contrast (CPT® 70553)
Assess cardiac function in HSCT	• Echocardiogram (CPT® 93306, CPT® 93307 or CPT® 93308) ◦ MUGA scan (CPT® 78472) in specific circumstances, see: **Oncologic Indications for Cancer Therapeutics-Related Cardiac Dysfunction (CTRCD) (CD-12.1)** in the Cardiac Imaging Guidelines
Assess pulmonary function in HSCT	• Pulmonary function tests

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Indication	Medically Necessary Imaging Study
Assess primary disease status in HSCT	• See disease-specific guidelines for end of therapy response assessment

Post-Transplant Imaging Criteria in HSCT:

- Disease response generally takes place at ~Day +30 (autos and some allos) or ~Day +100 (allos) post-transplant.

Indication	Medically Necessary Imaging Study
Assess known or suspected HSCT complications	• Site-specific imaging
Suspected hepatic GVHD (elevated liver enzymes)	• Abdominal US (CPT® 76700 or CPT® 76705)
Suspected Bronchiolitis Obliterans Syndrome (BOS)	• CT Chest without contrast (CPT® 71250)
Assess primary disease status post-transplant	• See disease-specific guidelines for end of therapy evaluation and surveillance
Individuals receiving tandem auto transplants (2-4 autos back-to-back, spaced 6 to 8 weeks apart)	• Guideline recommended imaging repeated after each transplant
New neurologic symptoms after CAR-T in individuals with HSCT	• MRI Brain without and with contrast (CPT® 70553)

Background and Supporting Information

Hematopoietic stem cell transplantation (HSCT) involves the infusion of hematopoietic stem cells obtained either from the patient (autologous transplant) or a donor (allogeneic transplant) and is used to treat a variety of malignant and non-malignant hematologic conditions. Autologous transplantation is primarily utilized as a rescue following high-dose chemotherapy, while allogeneic transplantation replaces the recipient immune system and is associated with a significantly greater degree of immunosuppression and prolonged immune reconstitution (Chan et al., 2023).

In an allogenic ("allo") transplant, the donor and recipient are different people, and there are multiple types depending on the source of the stem cells and degree of match

between donor and recipient. This is most commonly used in diseases originating in the hematopoietic system, such as leukemias and lymphomas, and bone marrow failure syndromes or metabolic disorders. Common types are:

- Matched sibling donor (MSD or MRD): Donor and recipient are full siblings and HLA-matched.
- Matched unrelated donor (MUD): Donor and recipient are HLA matched but not related to each other.
- Cord blood: Donor stem cells come from frozen umbilical cord blood not related to the recipient, sometimes from multiple different donors at once.
- Haploidentical transplant (haplo): Donor is a half-HLA match to the recipient, usually a parent.

In an autologous ("auto") transplant, the donor and recipient are the same person. The process involves delivery of high dose chemotherapy that is ablative to the bone marrow, followed by an infusion of one's own harvested stem cells. Allogeneic HSCT results in a much greater degree of immunosuppression than autologous HSCT because of the need to allow the new immune system to chimerize with the recipient's body. Immune reconstitution commonly takes more than a year for individuals who receive allogeneic HSCT, and individuals remain at high-risk for invasive infections until that has occurred (NCCN, 2026).

HSCT recipients are at high risk for complications involving multiple organ systems, particularly due to prolonged immunosuppression. Common complications include pulmonary infections, hepatic veno-occlusive disease, GVHD, and central nervous system abnormalities, all of which require targeted, site-specific imaging approaches rather than routine screening (Chan et al., 2023).

Evidence Discussion

The recommendation to limit pre-transplant imaging to clinically indicated studies is supported by NCCN guidance, which does not endorse routine imaging for infection screening in asymptomatic individuals and instead emphasizes targeted evaluation based on symptoms and clinical findings (NCCN, 2026). This is further supported by evidence demonstrating that screening sinus CT does not influence clinical management or predict post-transplant infectious outcomes. In a cohort of pediatric HSCT candidates, pre-transplant sinus CT findings were not associated with changes in therapy, transplantation timing, or development of post-transplant sinus disease, indicating limited clinical utility despite frequent imaging abnormalities (Harreld et al., 2020).

Similarly, restriction of CT imaging of other body regions without clinical indication is supported by NCCN and corroborated by evidence showing that routine CT screening of abdomen and pelvis rarely changes management and adds unnecessary radiation exposure and cost. Consensus recommendations emphasize that imaging should be

symptom-driven, as routine screening in asymptomatic individuals does not improve outcomes and may lead to incidental findings and unnecessary interventions (Chan et al., 2023; NCCN, 2026).

The recommendation for baseline cardiac assessment with echocardiography is supported by evidence and consensus guidelines demonstrating that evaluation of left ventricular function is essential prior to exposure to potentially cardiotoxic conditioning regimens. Echocardiography is the preferred modality due to its safety, lack of radiation, reproducibility, and ability to support serial monitoring of cardiac function in oncology populations, ensuring appropriate dosing and minimizing risk of treatment-related cardiac dysfunction (Plana et al., 2014).

Post-transplant imaging recommendations are supported by NCCN principles and evidence indicating that HSCT complications are heterogeneous and organ-specific, requiring targeted imaging strategies. Imaging is most effective when directed by clinical suspicion, as complications such as infection, graft-versus-host disease, bronchiolitis obliterans, and hepatic dysfunction require modality-specific evaluation. This site-specific approach maximizes diagnostic accuracy and facilitates early intervention while avoiding harms associated with unnecessary imaging (Chan et al., 2023; NCCN, 2026).

Health Equity Considerations

Hematopoietic stem cell transplantation (HSCT) is a potentially curative but highly complex, resource-intensive therapy, and substantial inequities persist across the transplant continuum, including referral, evaluation, donor availability, utilization, and post-transplant outcomes. Large registry and population-based analyses consistently demonstrate that racial and ethnic minority patients, individuals with public insurance, and those residing in lower-income or lower-education neighborhoods are significantly less likely to receive allogeneic HSCT, even when clinically eligible (Kang et al., 2026; Kumar et al., 2024; Landry, 2021). Structural barriers, including delayed referral from community settings, geographic distance from transplant centers, variable insurance coverage, and underrepresentation of minority donors in registries, contribute to disproportionate access and prolonged time to transplant among Black, Hispanic, and socioeconomically disadvantaged patients (Kumar et al., 2024; Landry, 2021). Recent data indicate that, despite expanded donor options such as haploidentical and cord blood transplantation, disparities in HSCT utilization have not meaningfully narrowed over time and, in some settings, continue to widen (Kang et al., 2026).

Beyond access, social determinants of health substantially influence transplant outcomes. Multiple studies demonstrate that lower socioeconomic status, adverse neighborhood conditions, communication barriers, financial hardship, and limited caregiver support independently predict worse survival, higher nonrelapse mortality, increased graft-versus-host disease, and infection-related deaths following allogeneic HSCT (Huguet et al., 2026; Garcia et al., 22024; Kumar et al., 2024). Psychosocial

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eligibility assessments, while intended to optimize safety, may unintentionally disadvantage lower-income patients, as socioeconomic status is strongly associated with unfavorable psychosocial scores and reduced likelihood of proceeding to transplant (Shoag et al., 2024; Garcia et al., 2024). Equitable access to standardized, evidence-based imaging for pre-transplant evaluation, response assessment, and post-transplant surveillance supports consistent risk stratification and early detection of complications across care settings. Integrating imaging recommendations with multidisciplinary, socially informed care pathways may help mitigate inequities by reducing variability in transplant decision-making, avoiding unnecessary delays, and supporting optimal outcomes for historically underserved populations (Blue et al., 2023; Melo et al., 2025).

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Reference (ONC-29)

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Medical Conditions with Cancer in the Differential Diagnosis (ONC-30)

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Fever of Unknown Origin (FUO) (ONC-30.1)

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Criteria

Indication	Medically Necessary Imaging Study
If physical examination, chest x-ray, and laboratory studies are non-diagnostic in individuals with FUO	• Echocardiogram (CPT® 93306) • Abdominal ultrasound (CPT® 76700) • MRI Brain without and with contrast (CPT® 70553)
Above studies (including PE/ENT exam, pelvic exam, and DRE with laboratory studies) have failed to demonstrate site of infection in individuals with FUO	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s): CPT® 78800, CPT® 78801, or CPT® 78802, CPT® 78804, CPT® 78803 or CPT® 78831 (SPECT), or CPT® 78830, or CPT® 78832 (SPECT/CT)
"B" symptoms in individuals with FUO	• See: **Non-Hodgkin Lymphomas (ONC-27)**
Any CNS sign/symptom accompanied by fever in individuals with FUO	• MRI Brain without and with contrast (CPT® 70553)
All individuals with FUO	• PET is not considered medically necessary in the work-up of individuals with FUO

Background and Supporting Information

Fever of unknown origin (FUO) is defined as a persistent fever ≥38.3°C (101°F) lasting at least 3 weeks without an identified cause after appropriate initial evaluation. Despite advances in diagnostic testing, FUO remains a challenging clinical entity, with no diagnosis established in a substantial proportion of patients. The major etiologic categories include infection, malignancy, noninfectious inflammatory disease, and miscellaneous causes, with infection remaining the most common and malignancy accounting for approximately 20%–30% of cases (Haidar & Singh, 2022; Palestro et al., 2023; Minamimoto, 2022). While fever is a classic "B" symptom of advanced lymphoma,

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a cancer-related fever presenting in isolation without any other signs or symptoms of neoplastic disease is rare.

Evidence Discussion

The recommendation for initial use of echocardiography, abdominal ultrasound, and MRI brain following nondiagnostic clinical evaluation is supported by evidence demonstrating that infectious etiologies, including endocarditis, intra-abdominal abscess, and central nervous system infections, are the most common causes of FUO. These modalities provide high diagnostic sensitivity (approximately 80%–86% in aggregate across studies) and are favored due to their ability to evaluate common etiologies without exposing patients to ionizing radiation. This aligns with structured diagnostic approaches emphasizing targeted, low-risk imaging early in the workup (Haidar & Singh, 2022; Wright et al., 2024; Mulders-Manders et al., 2021).

The use of contrast-enhanced CT of the chest, abdomen, and pelvis as second-line imaging is supported by its ability to identify occult malignancy, abscess, and inflammatory disease when first-line studies are unrevealing. CT provides comprehensive anatomic detail with reported sensitivity approaching 90% and moderate specificity for determining the cause of FUO. However, its use is appropriately delayed until after lower-risk modalities due to radiation exposure and lower diagnostic yield when used indiscriminately in early evaluation (Minamimoto, 2022; Haidar & Singh, 2022).

Radiopharmaceutical localization studies, including technetium-based scans and SPECT/SPECT-CT, are supported for persistent diagnostic uncertainty due to their high specificity (approximately 93%–94%) in localizing infectious or inflammatory foci. However, these modalities are limited by lower sensitivity, longer imaging times, and reduced availability, supporting their role as adjunctive tools rather than first-line imaging (Palestro et al., 2023; Minamimoto, 2022).

The recommendation against routine PET/CT in FUO reflects a critical balance between diagnostic benefit and potential harm. Although FDG PET/CT demonstrates high sensitivity (approximately 84%–86%) and can contribute to diagnosis in up to 50%–60% of cases, its specificity is limited (approximately 52%–63%), resulting in a significant rate of false-positive findings due to nonspecific uptake (Kan et al., 2019; Palestro et al., 2023; Minamimoto, 2022). This can lead to unnecessary invasive procedures, additional imaging, increased cost, and patient anxiety. Furthermore, while FDG PET/CT may improve diagnostic efficiency and reduce time to diagnosis in selected cases, evidence suggests that its optimal role is as a second-line or problem-solving modality after conventional evaluation rather than routine first-line imaging. Early use may reduce hospitalization and cost in select populations, but variability in specificity and the lack of consensus regarding its placement in diagnostic algorithms support its exclusion as medically necessary in standard FUO workup (Palestro et al., 2023; Minamimoto, 2022).

Finally, evidence demonstrates that negative FDG PET/CT findings are frequently associated with favorable outcomes and spontaneous resolution of fever, reinforcing that aggressive imaging is not always required in the absence of clinical deterioration. This supports a conservative, stepwise imaging strategy that prioritizes clinically indicated modalities and minimizes unnecessary radiation exposure and downstream interventions while maintaining diagnostic accuracy (Mulders-Manders et al., 2021; Palestro et al., 2023).

Health Equity Considerations

Fever of unknown origin (FUO) poses distinct health equity challenges because its diagnosis depends heavily on access to prolonged hospitalization, advanced laboratory testing, and high-yield imaging modalities. Contemporary studies demonstrate that FUO populations are disproportionately older, multimorbid, and affected by malignancy or immunosuppression, all of which are more prevalent among individuals with lower socioeconomic status and reduced access to longitudinal specialty care (De Pascali et al., 2025; Kaya et al., 2025). Diagnostic yield varies substantially by geography and healthcare setting, with infectious etiologies predominating in lower-resource regions and non-infectious inflammatory diseases and malignancies more common in tertiary centers in high-income countries, reflecting structural differences in access to imaging, subspecialty consultation, and invasive diagnostics (Kaya et al., 2025). Seasonal clustering related to vector-borne diseases and emerging infections further underscores the importance of equitable public health surveillance and geographically informed diagnostic strategies, particularly for populations with limited access to preventive care and timely evaluation (De Pascali et al., 2025).

Imaging plays a central role in reducing inequities in FUO evaluation when applied consistently and judiciously. Advanced imaging, particularly FDG PET/CT, has the highest diagnostic yield for malignancy and deep-seated infection, shortens time to diagnosis, and may reduce prolonged hospitalization when incorporated into structured, stepwise algorithms (Kaya et al., 2025). However, unequal access to PET/CT and subspecialty imaging can contribute to delayed diagnosis, excess empiric antibiotic use, and poorer outcomes among underserved patients, including older adults, people living with HIV, and those receiving immunosuppressive therapy (De Pascali et al., 2025; Kaya et al., 2025). Standardized, evidence-based imaging pathways for FUO can help mitigate these disparities by promoting timely escalation to high-yield imaging when clinically appropriate, minimizing unnecessary testing, and supporting equitable diagnostic evaluation across diverse care settings and populations.

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Unexplained Weight Loss (ONC-30.2)

ON.MC.0030.2.A
v1.0.2027

Criteria

- Initial workup for all individuals may include appropriate detailed history, physical exam, baseline laboratory studies (e.g., CBC, CMP, HgbA1c, ESR/CRP, infectious workup, stool hemoccult, endocrine evaluation to rule out thyroid, pituitary, or gonadal dysfunction, etc.), chest x-ray, age-appropriate cancer screening, and neurological evaluation to rule out depression/dementia.
- Additional workup is directed to evaluate specific signs, symptoms, red flags, or abnormalities detected on initial workup. See condition-specific imaging guidelines for additional details.
- PET is not considered medically necessary in the work-up of individuals with unexplained weight loss.
- Being on a GLP-1 does not preclude a workup for unexplained weight loss. If provider believes the individual's weight loss is not fully explained by the GLP-1, these guidelines should be used to guide imaging as for all other individuals.

Indication	Medically Necessary Imaging Study
CNS symptoms or abnormal pituitary hormones in individuals with unexplained weight loss	• MRI Brain or Sella Turcica without and with contrast (CPT® 70553)
Abnormal thyroid function in individuals with unexplained weight loss	• Thyroid ultrasound (CPT® 76536)
Abnormal liver function in individuals with unexplained weight loss	• Abdominal ultrasound (CPT® 76700)
Abnormal kidney function in individuals with unexplained weight loss	• Ultrasound Kidney and Bladder (CPT® 76770 or CPT® 76775)
Suspected cardiac dysfunction in individuals with unexplained weight loss	• Echocardiogram (CPT® 93306)
Non-smokers with unexplained weight loss	• Chest x-ray ◦ CT Chest with contrast (CPT® 71260) to evaluate abnormalities on chest x-ray

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Indication	Medically Necessary Imaging Study
Current or former smokers with unexplained weight loss	• CT Chest with contrast (CPT® 71260)
Dysphagia or early satiety in individuals with unexplained weight loss	See: **Dysphagia and Esophageal Disorders (NECK-3)**
GI bleeding in individuals with unexplained weight loss	See: **GI Bleeding (AB-22)**
Abdominal pain without red flag signs in individuals with unexplained weight loss	See: **Abdominal Pain (AB-2)**
Suspected pancreatic cancer in individuals aged ≥60 years with weight loss and at least one of the following: • Diarrhea • Back pain • Abdominal pain • Nausea/vomiting • Constipation • New onset diabetes • Abnormal labs (CA 19-9, LFTs) • Non-diagnostic or negative abdominal ultrasound	Any ONE of the following: • CT Abdomen with contrast (CPT® 74160) • CT Abdomen and Pelvis with contrast (CPT® 74177) • MRI Abdomen without and with contrast (CPT® 74183) See also: **Abdominal Pain (AB-2)**
If all of the above do not identify cause of weight loss	Any of the following, if not previously performed: • CT Chest with contrast (CPT® 71260) • CT Abdomen and Pelvis (CPT® 74177) with contrast

Background and Supporting Information

Unintentional (unexplained) weight loss is generally defined as loss of ≥5% of body weight over 6 months or less without an identifiable reason and is associated with increased morbidity and mortality, particularly in older adults (Gaddey & Holder, 2021; Durmuş et al., 2022; Metalidis et al., 2008). Weight loss is a nonspecific but clinically important presentation with a broad differential diagnosis including malignancy, nonmalignant organic disease, and psychiatric etiologies, with nonmalignant causes

accounting for the majority of cases (Bosch et al., 2017; Nicholson et al., 2018; Metalidis et al., 2008).

Malignancy is identified in a minority of individuals with unexplained weight loss, generally ranging from approximately 20% to 30%, and is most commonly associated with gastrointestinal, lung, and hematologic cancers (Nicholson et al., 2018; Bosch et al., 2017; Metalidis et al., 2008). Psychiatric causes, particularly major depressive disorder, are also common and may present primarily with weight loss in older adults, often without overt mood symptoms (Durmuş et al., 2022; Gaddey & Holder, 2021).

Weight loss is also recognized as a nonspecific symptom that may be associated with multiple cancer types but with relatively low predictive value when present in isolation. Risk-based diagnostic strategies therefore apply thresholds of suspicion to guide further investigation, balancing earlier detection with potential harms of over-investigation such as radiation exposure, incidental findings, and unnecessary procedures (National Collaborating Centre for Cancer, 2015; Nicholson et al., 2018).

Evidence Discussion

The recommendation to begin with symptom-directed evaluation and baseline testing prior to advanced imaging is supported by evidence demonstrating that most serious underlying causes of unexplained weight loss can be identified through initial clinical assessment. Prospective data show that all individuals with malignancy had abnormalities on baseline evaluation, including physical examination, laboratory studies, chest x-ray, or abdominal ultrasound, indicating high sensitivity of initial workup for clinically significant disease (Metalidis et al., 2008). This supports restricting early imaging to findings-driven evaluation rather than routine advanced imaging.

The use of targeted first-line imaging based on specific abnormalities (e.g., thyroid ultrasound, abdominal ultrasound, renal ultrasound, echocardiography, or MRI brain) is supported by the heterogeneous etiologies of weight loss. Organic diseases affecting endocrine, gastrointestinal, renal, and cardiopulmonary systems are frequently identified and are best evaluated using modality-specific imaging guided by clinical or laboratory abnormalities (Gaddey & Holder, 2021; Durmuş et al., 2022; Bosch et al., 2017). This approach improves diagnostic yield and avoids unnecessary radiation exposure and over-imaging.

Escalation to CT imaging of the chest, abdomen, and pelvis when baseline evaluation is negative but clinically significant weight loss persists is supported by evidence demonstrating that a subset of malignancies may be detected only on advanced imaging. While a normal baseline evaluation substantially lowers the likelihood of malignancy, additional imaging may identify cancers such as lung, pancreatic, colorectal, and lymphoma in selected patients, particularly those with persistent or progressive symptoms (Nicholson et al., 2018; Bosch et al., 2017; Metalidis et al., 2008).

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Risk-based imaging strategies, including CT chest for smokers and abdominal imaging for individuals with features concerning for pancreatic cancer, are supported by predictive modeling and cancer diagnostic frameworks. Clinical guidance emphasizes the use of symptom combinations and risk factors (e.g., age, smoking status) to refine cancer probability, ensuring that imaging is directed toward higher-risk populations while minimizing unnecessary testing in low-risk individuals (NCCC, 2015; Nicholson et al., 2018).

The recommendation against routine PET/CT is supported by the absence of evidence demonstrating diagnostic accuracy or clinical benefit in unexplained weight loss. No prospective data define sensitivity or specificity of PET in this population, and its use can lead to false-positive findings, incidental uptake, and unnecessary invasive procedures. Case-based evidence further demonstrates that PET/CT findings may reflect nonmalignant or psychiatric etiologies, resulting in additional testing without improving outcomes (Durmuş et al., 2022; Gaddey & Holder, 2021).

Health Equity Considerations

Unintentional weight loss (UWL) presents important equity challenges because recognition, evaluation, and follow-up are strongly influenced by age, gender, socioeconomic status, and patterns of healthcare engagement. UWL is frequently under-recognized in primary care, with fewer than one quarter of cases documented by clinicians, even though it may represent an early or isolated manifestation of malignancy or other serious disease (Rao et al., 2023). Evidence from large primary-care cohorts demonstrates that while the absolute risk of cancer associated with UWL is modest, it varies meaningfully by age and sex, and is highest among older adults, particularly men, underscoring the need for equitable access to timely diagnostic evaluation rather than reliance on symptom severity alone (Withrow et al., 2022). Missed or delayed recognition disproportionately affects individuals with fewer healthcare encounters, fragmented continuity of care, or competing social stressors, increasing the risk that medically significant weight loss is normalized or attributed to aging, lifestyle, or psychosocial factors without appropriate evaluation.

Socioeconomic disadvantage further shapes how patients perceive weight loss and how clinicians respond to it. Qualitative evidence shows that older adults from more deprived backgrounds are less likely to raise concerns about unintentional weight loss, more likely to internalize stigma or view weight loss as desirable or inevitable, and less empowered to challenge clinical reassurance or request further assessment (Newton-Clarke et al., 2025). These dynamics contribute to structural inequities in diagnostic pathways, particularly for imaging-based cancer evaluation, where earlier escalation may depend on patient advocacy or clinician suspicion. Standardized imaging criteria for UWL can help reduce variation driven by implicit bias, communication disparities, and resource access by supporting consistent decision-making across populations. Applying evidence-based imaging pathways when clinically indicated helps

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ensure that patients with unintentional weight loss, regardless of socioeconomic status, age, or prior body weight, receive equitable evaluation for potential malignancy while minimizing unnecessary testing and delays.

Oncology Imaging Guidelines

Paraneoplastic Syndromes (ONC-30.3)

ON.MC.0030.3.A
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Criteria

- The following are the most common symptoms of paraneoplastic syndromes known to arise from various malignancies:
  - Hypertrophic Pulmonary Osteoarthropathy: Often presents as a constellation of rheumatoid-like polyarthritis, periostitis of long bones, and clubbing of fingers and toes
  - Amyloidosis
  - Hypercalcemia
  - Hypophosphatemia
  - Cushing's Syndrome
  - Somatostatinoma syndrome (vomiting, abdominal pain, diarrhea, cholelithiasis)
  - Syndrome of inappropriate antidiuretic hormone secretion (SIADH)
  - Polymyositis/dermatomyositis
  - Opsoclonus
  - Paraneoplastic sensory neuropathy
  - Subacute cerebellar degeneration
  - Eaton-Lambert syndrome (a myasthenia-like syndrome)
  - Second event of unprovoked thrombosis
  - Disseminated Intravascular Coagulation
  - Migratory thrombophlebitis
  - Polycythemia
  - Chronic leukocytosis and/or thrombocytosis
  - Elevated tumor markers (including but not limited to: CEA, CA 19-9, CA 27-9, CA 15-3, CA 125, inhibin A and B, AFP, unexplained HCG)
  - Cryptogenic stroke (see also: **HD-21.3)**
- See: **Muscle Disorders (PN-6)** in the Peripheral Nerve Disorders Imaging Guidelines.
- See: **Multiple Myeloma and Plasmacytomas (ONC-25)** for evaluation of possible multiple myeloma.
- See: **Abnormal Non-Invasive Prenatal Testing (NIPT) and Maternal Malignancy (PV-15.5)** in the Pelvis Imaging Guidelines for NIPT Paraneoplastic syndromes.

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Indication	Medically Necessary Imaging Study
Initial evaluation of paraneoplastic syndromes	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast
ANY of the following in individuals with paraneoplastic syndromes: • Abnormality on conventional imaging difficult to biopsy • Inconclusive conventional imaging • Documented paraneoplastic antibody and conventional imaging fails to demonstrate primary site	• PET/CT (CPT® 78815 or CPT® 78816)
Subsequent evaluation for known paraneoplastic syndrome	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast every 6 months for 2 years after initial imaging for Lambert-Eaton Myasthenia syndrome • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast every 6 months for 4 years for all other paraneoplastic syndromes
Systemic mastocytosis in individuals with paraneoplastic syndromes	ANY ONE of the following: • CT Abdomen and Pelvis (CPT® 74177) with contrast • MRI Abdomen (CPT® 74183) and MRI Pelvis (CPT® 72197) without and with contrast • PET/CT scan is not considered medically necessary for evaluation of mastocytosis
First episode of unprovoked DVT/ VTE in individuals with paraneoplastic syndromes	• Imaging to evaluate for malignancy is not considered medically necessary

Indication	Medically Necessary Imaging Study
Second unprovoked DVT/PE in individuals with paraneoplastic syndromes	• Imaging may be considered in the setting of a negative work-up for inherited thrombophilia and antiphospholipid syndrome
Thyroid US is considered medically necessary for elevated CEA.	

Background and Supporting Information

Paraneoplastic syndromes (PNS) are clinical disorders caused by malignancy-related immune or humoral mechanisms and are not due to direct tumor invasion, metastasis, or treatment effects (Badawy et al., 2023). These syndromes frequently affect neurologic, endocrine, hematologic, and metabolic systems and may precede detection of an underlying malignancy, sometimes by months to years, creating a diagnostic interval during which imaging may initially be negative (Badawy et al., 2023; Sundermann et al., 2017).

Paraneoplastic neurologic syndromes are strongly associated with specific malignancies, particularly small cell lung cancer, and are often linked to the presence of onconeural antibodies, which increase the likelihood of identifying an underlying tumor (Sundermann et al., 2017). Tumors associated with PNS are frequently small, clinically occult, or suppressed by immune mechanisms, which contributes to difficulty in detection and underscores the need for sensitive imaging strategies (Sundermann et al., 2017).

Evidence Discussion

The use of contrast-enhanced CT of the chest, abdomen, and pelvis as first-line imaging is supported by its ability to evaluate the most common sites of malignancy associated with paraneoplastic syndromes, particularly thoracic and abdominal tumors such as small cell lung cancer (Sundermann et al., 2017; Badawy et al., 2023). Reported sensitivity of CT in this setting ranges from approximately 30% to 82%, with specificity between 71% and 100%, demonstrating moderate-to-high diagnostic accuracy while providing necessary anatomic detail for lesion characterization and biopsy planning (Sundermann et al., 2017). This supports CT as the preferred initial modality balancing diagnostic yield and accessibility.

PET/CT is appropriately reserved for cases with inconclusive conventional imaging, inaccessible lesions, or documented paraneoplastic antibodies, as its diagnostic performance improves in higher-risk populations (Sundermann et al., 2017). FDG PET/CT demonstrates sensitivity ranging from approximately 75% to 100% with variable

specificity, and pooled analyses report tumor detection in approximately 23%–24% of patients with suspected paraneoplastic syndromes (Sundermann et al., 2017). These findings support its role as a second-line or problem-solving modality capable of identifying metabolically active lesions and alternative biopsy sites when CT is nondiagnostic. However, PET/CT is not recommended as first-line imaging due to important limitations, including false-negative findings in small or low-metabolic tumors and false-positive uptake in inflammatory or physiologic processes (Sundermann et al., 2017; Badawy et al., 2023). False positives commonly occur in areas such as lymph nodes, gastrointestinal tract, and inflammatory lung disease, while false negatives may occur in breast, gastrointestinal, hepatic, and head and neck malignancies (Sundermann et al., 2017). These limitations increase the risk of unnecessary invasive procedures and support a stepwise imaging approach beginning with CT.

The recommendation for serial CT imaging in patients with suspected or confirmed paraneoplastic syndromes is supported by evidence that malignancy may emerge after initial negative imaging, with documented cases of delayed tumor detection months to years after symptom onset (Sundermann et al., 2017; Badawy et al., 2023). This supports periodic surveillance imaging, particularly within the first several years, when the probability of tumor detection remains clinically meaningful.

For systemic mastocytosis, cross-sectional imaging with CT or MRI of the abdomen and pelvis is supported by NCCN recommendations for evaluation of organ involvement, including liver, spleen, lymph nodes, and bone (NCCN, 2026). PET/CT is not recommended in this context due to lack of established diagnostic benefit, reinforcing modality selection based on expected disease distribution and imaging utility (NCCN, 2026).

Finally, the approach to imaging in venous thromboembolism within the context of paraneoplastic syndromes reflects a risk-based strategy. Evidence demonstrates that extensive imaging following a first unprovoked event has low diagnostic yield and is not cost-effective in the absence of additional clinical indicators of malignancy, whereas a second unprovoked event increases suspicion and justifies cross-sectional imaging (Rutherford et al., 2007; Harlos et al., 2019). This approach balances early cancer detection with avoidance of unnecessary imaging and associated harms.

Health Equity Considerations

Paraneoplastic syndromes (PNS) present substantial equity challenges because they are rare, clinically heterogeneous, and frequently precede the diagnosis of an underlying malignancy, making early recognition highly dependent on clinician awareness, access to specialty care, and availability of advanced diagnostic resources. Population-based data demonstrate that PNS carry a disproportionately high burden of morbidity and mortality relative to their low incidence, with significant disability-adjusted life years attributable largely to delayed diagnosis and neurologic impairment (Shah et al., 2021).

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These challenges are magnified for patients facing structural barriers to care, including limited access to neurologic subspecialists, autoantibody testing, or timely oncologic imaging, which can delay tumor identification and definitive treatment. As recognition of PNS has increased with improved serologic assays and expanded diagnostic criteria, disparities may widen if such tools are not equitably accessible across healthcare settings (Shah et al., 2021).

Health equity considerations are particularly salient for cutaneous paraneoplastic syndromes in individuals with skin of color, where pigment-modified presentations can obscure classic diagnostic features and contribute to missed or delayed cancer detection. Evidence shows that paraneoplastic dermatoses such as dermatomyositis and malignant acanthosis nigricans often appear atypically in darker skin tones, and underrepresentation of skin of color in medical education further compounds diagnostic inequities (Wahab et al., 2025). These delays have measurable oncologic consequences, including more advanced cancer stage at presentation and poorer outcomes. Standardized imaging pathways informed by paraneoplastic suspicion, rather than reliance on stereotypical clinical appearances, can help mitigate bias and variability in care. Ensuring equitable thresholds for diagnostic escalation, including early tumor-directed imaging when PNS is suspected, supports timely cancer detection across diverse populations and helps reduce disparities driven by diagnostic invisibility and uneven access to specialty expertise (Shah et al., 2021; Wahab et al., 2025).

Oncology Imaging Guidelines

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v1.0.2027

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Metastatic Cancer, Carcinoma of Unknown Primary Site, and Other Types of Cancer (ONC-31)

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General Criteria (ONC-31.0)

ON.UP.0031.0.A

v1.0.2027

- Guideline sections Lung Metastases (ONC-31.1) through Spinal Vertebral Metastases (ONC-31.6) are designed to supplement the disease-specific guidelines when the disease-specific guidelines do not provide guidance on the clinical scenario in question.
- These sections can also be used if the cancer type is rare and does not have its own diagnosis-specific imaging guidelines.
- These sections may also be used for lesions suspicious for cancer that do not have guidance in other disease-specific areas of the guidelines.

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Lung Metastases (ONC-31.1)

ON.UP.0031.1.A
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Criteria

Indication	Medically Necessary Imaging Study
New or worsening signs or symptoms suggestive of metastatic lung involvement or new or worsening chest x-ray abnormality	• CT Chest with contrast (CPT® 71260) • CT Chest without contrast (CPT® 71250) if there is a contraindication to CT contrast or only parenchymal lesions are being evaluated
Chest wall or brachial plexus involvement	• MRI Chest without and with contrast (CPT® 71552)
ONE of the following **and** no diagnosis-specific guideline regarding PET imaging: • Lung nodule(s) 8mm or greater • Confirm solitary metastasis amenable to resection on conventional imaging	• PET/CT (CPT® 78815) • When primary cancer known, PET request should be reviewed by primary cancer guideline
Previous or current malignancy and pulmonary nodule(s) that would reasonably metastasize to the lungs	• CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) at 3, 6, 12, and 24 months from the first study • For subsolid nodules, ongoing surveillance after 24 months is considered medically necessary. Refer to **Incidental Pulmonary Nodules Detected on CT Images (CH-16.2)** for follow-up for subsolid nodules after the 24 month timeframe.

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Indication	Medically Necessary Imaging Study
Suspected drug-induced or radiation-induced pulmonary toxicity	CT Chest with contrast (CPT® 71260) or CT Chest without contrast (CPT® 71250) for the following: • Initial evaluation • Repeat imaging at the timing of the discretion of the treating provider ◦ Worsening symptoms or PFTs ◦ Guide for steroid taper ◦ Baseline prior to re-exposure to offending agent

Background and Supporting Information

Pulmonary metastases represent hematogenous dissemination of malignancy to the lungs and most commonly manifest as single or multiple pulmonary nodules with variable size, number, and distribution on imaging (Szaro et al., 2021; Christensen et al., 2024). Metastatic nodules are frequently located in the lung periphery and may demonstrate a wide size range, with multiplicity and lower lobe predominance often suggesting metastatic disease rather than primary lung malignancy (MacMahon et al., 2017; Szaro et al., 2021).

Risk stratification of pulmonary nodules is primarily based on imaging characteristics, including size, growth, and morphology, with increasing size strongly associated with increased probability of malignancy (MacMahon et al., 2017; Christensen et al., 2024). Nodules ≥8mm are associated with a higher likelihood of malignancy and warrant further diagnostic evaluation, including advanced imaging or tissue sampling depending on clinical context (MacMahon et al., 2017; Christensen et al., 2024). In patients with known malignancy, pulmonary nodules are more likely to represent metastatic disease, although benign etiologies such as infection or inflammatory processes remain in the differential (Szaro et al., 2021; Christensen et al., 2024).

Growth kinetics are a critical determinant of malignancy, as most malignant pulmonary nodules demonstrate measurable growth over time, with metastases often showing interval progression within months (MacMahon et al., 2017; Szaro et al., 2021). Stability of a nodule over an extended interval significantly reduces the likelihood of malignancy, with data supporting that nodules stable for greater than 24 months are unlikely to represent active cancer in most clinical scenarios (MacMahon et al., 2017; Christensen et al., 2024).

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Evidence Discussion

CT of the chest is supported as the initial imaging modality in individuals with suspected pulmonary metastases due to its high sensitivity for detecting pulmonary nodules and ability to evaluate both lung parenchyma and mediastinal structures (Szaro et al., 2021; Christensen et al., 2024). Contrast-enhanced CT improves assessment of mediastinal lymph nodes and soft tissue structures, while noncontrast CT remains appropriate when evaluating isolated parenchymal lesions or when contrast is contraindicated (Szaro et al., 2021). This approach balances diagnostic accuracy with patient safety by limiting unnecessary contrast exposure while maintaining high detection capability for metastatic disease.

Serial CT imaging for pulmonary nodules in patients with known or suspected malignancy is supported by evidence demonstrating that growth over time is a key indicator of malignancy, whereas stability over prolonged intervals strongly suggests benign disease (MacMahon et al., 2017; Christensen et al., 2024). Recommended follow-up intervals derived from nodule management data demonstrate that most malignant nodules will show growth within 3–24 months, supporting structured surveillance strategies such as imaging at 3, 6, 12, and 24 months when disease-specific guidance is not otherwise defined (MacMahon et al., 2017; Szaro et al., 2021). This strategy minimizes missed diagnoses while avoiding excessive imaging in nodules that remain stable.

MRI is supported for evaluation of suspected chest wall or brachial plexus involvement because of its superior soft tissue contrast resolution compared with CT, allowing more accurate delineation of tumor infiltration into adjacent structures (Szaro et al., 2021). Accurate characterization of local invasion is essential for staging and treatment planning, particularly when surgical resection is being considered, and CT alone may be insufficient for evaluating complex soft tissue involvement.

Selective use of PET/CT is supported for nodules ≥8mm or when confirming a solitary metastasis amenable to resection, as metabolic imaging improves detection of occult metastatic disease and reduces the risk of futile invasive procedures (Christensen et al., 2024; Szaro et al., 2021). However, routine PET/CT surveillance is not supported due to limitations including false-positive findings from inflammatory processes, false negatives in small or low-metabolic lesions, increased radiation exposure, and cost considerations (Christensen et al., 2024; Szaro et al., 2021). Restricting PET/CT to higher-risk scenarios aligns diagnostic benefit with potential harms and supports a stepwise, risk-adapted imaging approach.

Health Equity Considerations

Lung metastases represent a substantial and growing public health burden, with population-level data demonstrating that approximately 4% of all newly diagnosed cancer cases in the United States present with synchronous lung metastases and that

this proportion has increased over time, largely reflecting advances in imaging and stage migration (Chen et al., 2021). These trends raise important equity concerns, as detection of lung metastases is highly dependent on access to timely, high-quality cross-sectional imaging and consistent staging practices. Population-based analyses show that patients presenting with lung metastases are more likely to be older, male, and from racialized groups, and to have more advanced primary tumor and nodal stage at diagnosis, suggesting that delayed cancer detection and downstream inequities in access to screening and early diagnostic services contribute to more advanced metastatic presentation in vulnerable populations (Chen et al., 2021). Because the presence of lung metastases is independently associated with worse overall survival across most primary cancer sites, delayed or uneven access to staging imaging may directly exacerbate outcome disparities.

Equitable application of oncologic imaging is therefore central to reducing disparities in outcomes related to lung metastases. Evidence demonstrates that synchronous lung metastases confer significantly poorer survival compared with extrapulmonary metastases alone, even after adjustment for age, sex, race, stage, and the presence of other metastatic sites (Chen et al., 2021). Standardized, evidence-based recommendations for thoracic imaging help mitigate variability driven by healthcare access, referral patterns, or implicit bias by ensuring that patients with high-risk primary tumors receive appropriate evaluation regardless of demographic factors. Consistent adherence to guideline-directed imaging pathways supports earlier identification of lung metastases, more accurate prognostication, and timely initiation of systemic or local therapies, thereby promoting more equitable cancer care across diverse patient populations (Chen et al., 2021).

Oncology Imaging Guidelines

Liver Metastases and Liver-Directed Therapies (ONC-31.2)

ON.UP.0031.2.A
v1.0.2027

Criteria

- Yitrium-90 Radioembolization (Y90-RE) is also known either as Selective Internal Radiation Therapy (SIRT) or trans-arterial radioembolization (TARE). Y90-RE is considered medically necessary for inoperable hepatocellular carcinoma and metastatic disease to the liver. Yitrium-90 resin or glass microsphere is injected into the hepatic vessel which supplies the tumor bed. This delivers high radiation dose to the tumor selectively.
- Yitrium-90 Radioembolization consists of three parts:

1. The pre-treatment planning angiogram with Technetium 99m macroaggregated albumin (Tc-MAA). The Tc-MAA acts as surrogate for biodistribution of application of Y-90. Planar or SPECT/CT are performed for calculation of lung shunt fraction and identification of extra hepatic uptake. The assessment of hepatopulmonary shunt is important in the determination eventual radiation dose. Presence of extra-hepatic uptake may preclude treatment or require coil embolization.
2. Yitrium-90 Radioembolization treatment is typically done 7-10 days after mapping.
3. Post-treatment imaging may be done to confirm tumor localization.

- Ablation of liver metastases or primary HCC may be performed utilizing chemical, chemotherapeutic, radiofrequency, or radioactive isotope. Regardless of the modality of ablation, PET is not considered medically necessary for assessing response to this mode of therapy.

Indication	Medically Necessary Imaging Study
New or worsening signs or symptoms suggestive of metastatic liver involvement or new elevation in LFTs	• CT Abdomen with (CPT® 74160) or without and with (CPT® 74170) contrast

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Indication	Medically Necessary Imaging Study
ANY of the following in individuals with suspected liver metastases: • Considering limited resection • Inconclusive CT findings • Inconclusive liver findings on PET/CT	• MRI Abdomen without and with contrast (CPT® 74183)
ONE of the following in individuals with suspected liver metastases **and** no diagnosis-specific guideline regarding PET imaging: • Confirm solitary metastasis amenable to resection on conventional imaging • LFT's and/or tumor markers continue to rise and CT and MRI are negative	• PET/CT (CPT® 78815) ◦ When primary cancer known, PET request should be reviewed by primary cancer guideline
Monitoring of liver metastases that have been surgically resected	• Review according to primary cancer guideline
Evaluation of hepatic artery chemotherapy infusion or TACE (transarterial chemoembolization)	• CTA Abdomen (CPT® 74175) immediately prior to embolization ONE of the following studies immediately prior to and one month post-embolization, if not previously done: • CT Abdomen without and with contrast (CPT® 74170) • MRI Abdomen without and with contrast (CPT® 74183)

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Indication	Medically Necessary Imaging Study
Evaluation for hepatic artery radioembolization with Y-90 radioactive spheres (TheraSphere or SIR Spheres) for liver metastases or primary liver tumors	To assess hepatic vascular anatomy before the procedure, any ONE of the following: • 3D Rendering (CPT® 76377) if conventional hepatic angiogram is being performed • CTA Abdomen (CPT® 74175) ONE of the following studies PRE-treatment based upon provider preference: • Radiopharmaceutical Localization Limited Area (CPT® 78800 or CPT® 78801) • SPECT or SPECT/CT (CPT® 78803, 78831, 78830, or 78832) • CPT® 78835 may be approved as an add-on code with SPECT/CT codes only (CPT® 78803, 78831, 78830, or 78832) for calculation of lung shunt fraction if planar imaging (CPT® 78800 or CPT® 78801) not performed. Liver-lung shunt calculation is included in planar scans and does not require additional Lung Perfusion Scan ONE of the following studies POST-treatment based upon provider preference: • Radiopharmaceutical Localization Limited Area (CPT® 78800 or CPT® 78801) • SPECT or SPECT/CT (CPT® 78803, 78831, 78830, or 78832)
Monitoring of liver metastases or primary tumors following ablation, radioembolization, or chemoembolization	ONE of the following, immediately prior to ablation or embolization, 1 month post-ablation or embolization, then every 3 months for 2 years, and then every 6 months until year 5: • CT Abdomen without and with contrast (CPT® 74170) • MRI Abdomen without and with contrast (CPT® 74183)

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Background and Supporting Information

Liver metastases are the most common malignant lesions involving the liver due to its dual blood supply and filtration of portal venous blood, which facilitates hematogenous spread from extrahepatic malignancies (Maino et al., 2023). Accurate detection and characterization are critical because lesion number, distribution, and vascular characteristics directly influence management decisions, including eligibility for resection, locoregional therapy, or systemic treatment (Maino et al., 2023; Gore et al., 2017).

Liver-directed therapies, including ablation, transarterial chemoembolization (TACE), and radioembolization with yttrium-90 (Y-90), are established treatment options for unresectable or liver-dominant disease and are selected based on tumor burden, distribution, and hepatic functional reserve (Salem et al., 2023; NCCN, 2026). Y-90 radioembolization delivers targeted radiation via the hepatic arterial supply and is used in both primary and metastatic liver malignancies, often in patients with unresectable disease and preserved liver function (Barabasch et al., 2018; NCCN, 2026).

Evidence Discussion

Contrast-enhanced CT of the abdomen is supported as first-line imaging for suspected liver metastases because it enables evaluation of lesion number, vascular enhancement pattern, and associated intra-abdominal findings, which are critical for staging and treatment selection (Maino et al., 2023; Gore et al., 2017). CT is widely available and effective for identifying multifocal disease; however, its limitations in lesion characterization, particularly for small or atypical lesions, justify escalation to MRI when findings are indeterminate or when surgical resection is being considered (Gore et al., 2017; Maino et al., 2023). MRI provides superior soft tissue contrast and improved sensitivity for lesion detection and characterization, supporting its role as a problem-solving modality and for preoperative planning (Maino et al., 2023).

PET/CT is not recommended as first-line imaging for hepatic lesions because it has lower specificity compared with contrast-enhanced CT or MRI for lesion characterization, particularly in the liver where physiologic uptake and variable tumor metabolism may limit accuracy (Barabasch et al., 2018). However, PET/CT has value as a problem-solving tool in selected scenarios, including detection of occult metastatic disease when tumor markers or liver function tests continue to rise despite negative conventional imaging, or to confirm solitary disease prior to curative-intent resection to avoid unnecessary surgery (Barabasch et al., 2018). This selective use balances the benefit of identifying otherwise occult disease with the risks of false-positive findings, additional procedures, and radiation exposure.

Imaging before and after liver-directed therapies such as TACE or hepatic artery infusion is necessary for treatment planning and response assessment, as cross-sectional imaging allows evaluation of tumor viability, vascularity, and treatment-related changes

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(Salem et al., 2023). For Y-90 radioembolization, pre-treatment vascular mapping with CTA and nuclear medicine imaging is supported to assess hepatic arterial anatomy, measure lung shunt fraction, and detect extrahepatic tracer uptake, which are critical for patient safety and appropriate dose delivery (Salem et al., 2023; NCCN, 2026). Post-treatment imaging confirms localization and distribution of therapy, ensuring accurate delivery and identifying complications (Salem et al., 2023).

Ongoing surveillance after ablation or embolization with CT or MRI is supported by evidence demonstrating that cross-sectional imaging reliably detects residual or recurrent tumor and assesses treatment response over time (NCCN, 2026). MRI demonstrates superior diagnostic performance compared with PET/CT in the post-treatment setting, with higher sensitivity and predictive value for detecting viable tumor, while PET has lower sensitivity and may miss residual disease (Barabasch et al., 2018). This supports the recommendation against routine PET imaging for post-ablation or embolization surveillance and instead favors structured CT or MRI follow-up at defined intervals to balance early detection of recurrence with avoidance of unnecessary radiation and cost (NCCN, 2026; Singal et al., 2023).

Health Equity Considerations

Liver metastases, particularly from colorectal cancer, represent a setting in which potentially curative interventions are available, yet access to these therapies is unevenly distributed across patient populations. Population-based analyses consistently demonstrate that liver-directed therapies (LDT), including hepatectomy, ablation, and hepatic artery infusion chemotherapy, are substantially underutilized despite strong associations with long-term survival. Across national cohorts, patients who are Black, of lower socioeconomic status, female, or publicly uninsured are significantly less likely to receive liver-directed interventions, even after adjustment for comorbidity burden and clinical factors (Ahmed et al., 2022; Aquina et al., 2023; Martinez et al., 2026). Structural barriers, including limited access to high-volume hepatobiliary centers, variability in referral patterns, geographic distance, and differential assessment of resectability, contribute directly to inequitable treatment allocation, resulting in avoidable survival disparities for medically appropriate candidates.

Access to specialized centers plays a central role in mediating these disparities. Treatment at high-volume or academic centers is strongly associated with higher likelihood of receiving liver-directed therapy and with improved overall survival, yet patients from marginalized racial and socioeconomic groups are less likely to access such centers or to undergo definitive intervention once evaluated (Ahmed et al., 2022; Aquina et al., 2023; Martinez et al., 2026). Standardized, evidence-based imaging pathways for the detection, staging, and longitudinal assessment of liver metastases help promote equity by supporting timely identification of potentially resectable or ablatable disease regardless of demographic factors. Consistent guideline-driven imaging can facilitate earlier multidisciplinary referral, reduce subjective variability

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in determining treatment candidacy, and ensure that patients with liver-limited or oligometastatic disease are equitably considered for life-prolonging and potentially curative liver-directed therapies (Ahmed et al., 2022; Aquina et al., 2023; Martinez et al., 2026).

Oncology Imaging Guidelines

Brain Metastases (ONC-31.3)

ON.UP.0031.3.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Individual with cancer and signs or symptoms of CNS disease or known brain metastasis with new signs or symptoms.	• MRI Brain without and with contrast (CPT® 70553)
To determine candidacy for SRS, and a diagnostic thin-slice MRI Brain has not been performed in the preceding 30 days	• MRI Brain without and with contrast (CPT® 70553)
Stereotactic radiosurgery planning	• Unlisted MRI for treatment planning purposes (CPT® 76498)
Monitoring of brain metastases treated with surgery or radiation therapy	Post-treatment, then every 3 months for 1 year and every 4 months thereafter: • MRI Brain without and with contrast (CPT® 70553) ***Individuals treated with stereotactic radiosurgery alone may have MRI Brain without and with contrast (CPT® 70553) immediately after stereotactic radiosurgery, then every 2 months for the first year, and then every 6 months thereafter
Brain metastases treated with radiation therapy, with recent MRI Brain indeterminate in distinguishing radiation necrosis vs. tumor progression	• MRI Perfusion imaging (CPT® 70553)

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Indication	Medically Necessary Imaging Study
Brain metastases treated with radiation therapy, with recent MRI Brain and MR Perfusion studies both unable to distinguish radiation necrosis vs. tumor progression	• PET Metabolic Brain (CPT® 78608)
Any of the following: • Solitary brain metastasis suspected in individual with prior diagnosis of cancer • Brain metastases and no known primary tumor	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • Mammography for individuals assigned female at birth • PET/CT (CPT® 78815 or CPT® 78816) for ANY of the following: ◦ Inconclusive conventional imaging ◦ Confirm either stable systemic disease or absence of other metastatic disease ◦ When primary cancer known, PET request should be reviewed by primary cancer guideline unless there is no diagnosis-specific guideline regarding PET imaging
Monitoring of brain metastases on systemic therapy or surveillance (in absence of surgery or radiation therapy)	• MRI Brain without and with contrast (CPT® 70553) 2-3 months for 1-2 years, and then every 4-6 months indefinitely
Primary brain tumors	See: **Primary Central Nervous System Tumors (ONC-2)**
MR Spectroscopy (CPT® 76390) is not considered medically necessary for evaluation of metastatic brain cancer.	

Background and Supporting Information

Brain metastases are the most common intracranial malignancies, occurring in approximately 10–40% of cancer patients and outnumbering primary brain tumors by a factor of 10, with incidence increasing due to improved systemic cancer control and surveillance imaging (Mitchell et al., 2022; Mehrabian et al., 2019; Soffietti et al., 2017; Brenner & Patel, 2022). They most frequently arise from lung cancer, breast cancer, and melanoma, with hematogenous spread leading to preferential localization in regions

of highest cerebral blood flow such as the cerebral hemispheres (Mitchell et al., 2022; Soffietti et al., 2017).

Clinical manifestations of brain metastases vary depending on lesion location and burden, with common symptoms including headache, nausea, vomiting, focal neurologic deficits, seizures, and cognitive impairment, although some patients may remain asymptomatic (Mitchell et al., 2022; Soffietti et al., 2017). Because neurologic symptoms may precede diagnosis or occur in patients with unknown primary malignancy, imaging plays a central role in both detection and staging (Mehrabian et al., 2019; Brenner & Patel, 2022).

Management of brain metastases is multidisciplinary and depends on factors including number, size, location of lesions, performance status, and systemic disease burden, with treatment strategies incorporating surgery, stereotactic radiosurgery (SRS), whole brain radiotherapy (WBRT), and systemic therapies (Mitchell et al., 2022; Soffietti et al., 2017). Accurate imaging is essential not only for diagnosis but also for treatment planning, response assessment, and surveillance due to the risk of recurrence and treatment-related complications such as radiation necrosis (Mitchell et al., 2022; Brenner & Patel, 2022).

Evidence Discussion

MRI of the brain without and with contrast is supported as the primary imaging modality for individuals with cancer and signs or symptoms of central nervous system involvement, as well as for individuals with known brain metastases who develop new neurologic symptoms. MRI provides superior sensitivity compared with CT for detection of intracranial metastatic disease, particularly for small lesions, posterior fossa lesions, and multifocal disease. Contrast-enhanced MRI improves lesion detection and characterization, directly influencing treatment selection and eligibility for local therapies such as surgery or stereotactic radiosurgery (Mitchell et al., 2022; Mehrabian et al., 2019). Similarly, MRI is supported when determining candidacy for stereotactic radiosurgery because accurate lesion number, size, and location are essential for treatment planning and avoidance of undertreatment or inappropriate patient selection (Mitchell et al., 2022; Soffietti et al., 2017).

Serial MRI surveillance following surgery or radiation therapy is supported because intracranial recurrence, progression, and treatment-related complications remain common after local therapy. Regular post-treatment MRI allows earlier detection of local recurrence and distant intracranial failure, facilitating timely intervention while lesions remain amenable to additional local treatment. More frequent surveillance following stereotactic radiosurgery alone is supported by the increased risk of subsequent intracranial progression and the absence of whole-brain treatment, which places patients at continued risk for new metastatic lesions elsewhere in the brain (Mitchell et al., 2022; Soffietti et al., 2017). Similarly, ongoing MRI monitoring is supported in

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individuals managed with systemic therapy alone because intracranial progression may occur despite extracranial disease control (Mitchell et al., 2022).

For individuals previously treated with radiation therapy whose MRI findings are indeterminate for radiation necrosis versus tumor progression, MR perfusion imaging is supported as a problem-solving modality. Perfusion techniques assess tissue vascularity and hemodynamics, providing information that may help distinguish active tumor from treatment-related injury and thereby reduce unnecessary surgery, repeat radiation, or premature changes in systemic therapy. However, overlap between imaging characteristics may persist, particularly in complex lesions (Mitchell et al., 2022; Mehrabian et al., 2019). When both conventional MRI and MR perfusion remain inconclusive, metabolic brain PET imaging is supported because metabolic activity may provide additional diagnostic information that improves characterization of treatment-related change versus viable tumor (Mitchell et al., 2022; Mehrabian et al., 2019).

In individuals presenting with a solitary brain metastasis or brain metastases without an identified primary malignancy, systemic imaging with contrast-enhanced CT of the chest, abdomen, and pelvis is supported because the most common primary tumors originate outside the central nervous system. Mammography is supported when appropriate because breast cancer remains one of the leading causes of brain metastases. PET/CT is appropriately reserved for situations in which conventional imaging is inconclusive, when confirmation of stable systemic disease is needed, or when additional metastatic disease must be excluded. This selective approach maximizes diagnostic yield while limiting unnecessary radiation exposure, false-positive findings, and downstream testing associated with routine PET imaging (Mitchell et al., 2022; Mehrabian et al., 2019; Soffietti et al., 2017).

Health Equity Considerations

Brain metastases require timely access to advanced imaging, neurosurgical evaluation, stereotactic radiosurgery, and systemic therapies, making equitable delivery of care particularly vulnerable to social and structural determinants of health. Population-based analyses consistently demonstrate that socioeconomic status, geography, insurance coverage, and race influence both treatment receipt and survival in patients with brain metastases. Patients from lower socioeconomic strata are significantly less likely to receive radiation, chemotherapy, or surgical intervention and experience shorter overall survival, even after adjustment for tumor and demographic factors (Rodrigues et al., 2023). Rural residence and increased travel burden further limit access to high-volume or academic centers capable of delivering multimodal brain metastasis care, contributing to lower treatment rates and poorer outcomes for rural populations compared with urban counterparts (Riggs et al., 2023).

Racial and ethnic disparities compound these inequities. National database studies show that Black patients are less likely to be recommended or to receive surgery and

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chemotherapy and have among the shortest observed survival times, while Hispanic and Asian patients are also less likely to receive radiation or systemic therapy compared with non-Hispanic White patients (Jiang et al., 2023; Rodrigues et al., 2023). Importantly, analyses adjusting for socioeconomic factors suggest that differences in treatment access and resources rather than inherent biological differences alone account for much of the observed survival gap (Jiang et al., 2023). Standardized, evidence-based recommendations for brain imaging and surveillance help reduce variability driven by geography, insurance status, or referral bias. Consistent guideline-directed imaging supports earlier detection of brain metastases, facilitates timely multidisciplinary evaluation, and promotes equitable consideration for surgery, radiosurgery, and systemic therapies across diverse patient populations (Riggs et al., 2023; Rodrigues et al., 2023; Jiang et al., 2023).

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Adrenal Gland Metastases (ONC-31.4)

ON.UP.0031.4.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Differentiate benign adrenal adenoma from metastatic disease	• See: **Adrenal Cortical Lesions (AB-16.1)** in the Abdomen Imaging Guidelines
Known cancer and no known systemic metastases with: • New adrenal mass • Enlarging adrenal mass • Inconclusive findings on recent CT	If not done previously, ANY of the following: • CT Abdomen without contrast (CPT® 74150) • CT Abdomen without and with contrast (CPT® 74170, adrenal protocol) • MRI Abdomen without contrast (CPT® 74181) • MRI Abdomen without and with contrast (CPT® 74183) • CT-directed needle biopsy (CPT® 77012)
One of the following in individuals with suspected adrenal metastases and no diagnosis-specific guideline regarding PET imaging: • Biopsy is not feasible or is non-diagnostic • Isolated metastasis on conventional imaging and individual is a candidate for aggressive surgical management	• PET/CT (CPT® 78815) When primary cancer known, PET request should be reviewed by primary cancer guideline
Known extra-adrenal malignancy and undiagnosed adrenal mass being monitored off treatment	See: **General Criteria (ONC-1.0)**

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Background and Supporting Information

Adrenal masses are frequently encountered due to widespread use of cross-sectional imaging, with a prevalence ranging from approximately 2% to 10%, the majority of which are benign nonfunctioning adenomas (He et al., 2021; Romanisio et al., 2025). In patients with a known extra-adrenal malignancy, adrenal lesions may represent metastatic disease; however, benign etiologies remain common, necessitating accurate characterization to guide clinical management (Mody et al., 2021; Corwin et al., 2022).

Evidence Discussion

Cross-sectional imaging with CT or MRI is supported as the initial evaluation for adrenal masses in patients with known malignancy because these modalities provide critical information regarding lesion attenuation, washout characteristics, and internal composition that help differentiate benign adenomas from metastatic disease (Mody et al., 2021; Corwin et al., 2022). Noncontrast CT allows measurement of lesion attenuation, with low Hounsfield unit values strongly associated with benign adenomas, while contrast-enhanced CT washout analysis and MRI chemical shift imaging further improve specificity by identifying lipid content or enhancement patterns (He et al., 2021; Romanisio et al., 2025). Despite these strengths, a subset of adrenal lesions remains indeterminate, supporting escalation to additional modalities such as biopsy or advanced imaging when clinically indicated (Mody et al., 2021).

CT-guided biopsy is supported when imaging findings remain inconclusive and tissue diagnosis is required, particularly in patients with known malignancy where confirmation of metastatic disease will alter management (Mody et al., 2021; Corwin et al., 2022). However, biopsy carries procedural risks and requires exclusion of hormonally active tumors such as pheochromocytoma, reinforcing the importance of careful patient selection and use of imaging-based characterization when possible (Romanisio et al., 2025). This supports a stepwise approach prioritizing noninvasive imaging before invasive diagnostic procedures.

PET/CT is not recommended as first-line imaging due to variable specificity and risk of false-positive findings, as benign lesions such as adenomas, hyperplasia, and inflammatory processes may demonstrate increased FDG uptake (He et al., 2021; Romanisio et al., 2025). Diagnostic performance varies, with reported sensitivity around 83–85% and specificity near 90% depending on SUV thresholds, and both false-positive and false-negative results are well documented, particularly in certain tumor types or lesions with necrosis (He et al., 2021). Additionally, SUV-based thresholds (e.g., tumor-to-liver ratios around 1.5–2.5) improve diagnostic accuracy but remain imperfect, reinforcing that PET findings must be interpreted in the context of other imaging and clinical data (Romanisio et al., 2025; He et al., 2021). These limitations support restricting PET/CT to specific scenarios such as non-diagnostic biopsy or surgical planning.

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Selective use of PET/CT in cases where biopsy is not feasible or when confirming isolated metastasis prior to aggressive surgical management is supported by its ability to detect metabolically active disease and identify occult metastases, thereby reducing the risk of unnecessary or noncurative surgery (Mody et al., 2021; Romanisio et al., 2025). However, given the risk of false-positive uptake and potential downstream invasive procedures, PET/CT is best used as a problem-solving tool rather than routine imaging, aligning with a risk-adapted strategy that balances diagnostic yield with avoidance of unnecessary interventions (He et al., 2021; Corwin et al., 2022).

Health Equity Considerations

Adrenal gland metastases are increasingly identified through cross-sectional imaging performed for cancer staging or unrelated indications, making equitable access to high-quality imaging and subspecialty evaluation essential for accurate diagnosis and management. Large institutional series show that more than one-third of adrenal metastases are discovered incidentally and that the majority arise from lung, genitourinary, and gastrointestinal primaries, with renal cell carcinoma and lung cancer most frequently implicated (Mao et al., 2021; Panwar et al., 2024). Reliance on imaging characteristics alone to distinguish benign incidentalomas from metastatic disease is imperfect, particularly in patients without a known malignancy, where adrenal metastasis may represent the initial manifestation of an occult primary tumor (Panwar et al., 2024). Patients with limited access to consistent longitudinal imaging, endocrine consultation, or biopsy services may therefore experience delays in diagnosis, inappropriate reassurance, or missed opportunities for timely oncologic evaluation, exacerbating disparities in outcomes.

Equity concerns are further amplified in patients with bilateral adrenal metastases, who are at meaningful risk for primary adrenal insufficiency, a potentially life-threatening but often under-recognized condition. Population-based cohorts demonstrate that bilateral disease develops in up to 43% of patients over time and that adrenal insufficiency occurs in more than 12% of those with bilateral involvement, particularly among patients with larger tumors and certain primary cancer types (Mao et al., 2021). Early recognition depends on systematic imaging surveillance and biochemical assessment, which may be inconsistently applied in resource-limited settings. Standardized, evidence-based recommendations for adrenal imaging and follow-up help promote equity by supporting timely detection of metastatic involvement, appropriate escalation to biopsy or surgical consultation, and earlier identification of complications such as adrenal insufficiency. Consistent guideline-directed imaging pathways reduce variability driven by access, geography, or referral patterns and help ensure that patients with suspected adrenal metastases receive equitable, high-quality care regardless of socioeconomic or clinical context (Mao et al., 2021; Panwar et al., 2024).

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Bone (Non-Vertebral) Metastases (ONC-31.5)

ON.UP.0031.5.C
v1.0.2027

Criteria

- This guideline may be used for individuals with or without a history of malignancy, depending on the indications as listed below.

Indication	Medically Necessary Imaging Study
Individuals 40 years of age or older with no history of malignancy who have a symptomatic bone lesion seen on x-ray and malignancy is suspected	EITHER of the following: • CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT® 78306) OR • FDG PET/CT (CPT® 78815 or CPT® 78816)
Individuals less than 40 years of age with a bone lesion on x-ray	See: **Lesion of Bone (MS-10.2)**
Suspected bone metastasis due to ANY of the following in an individual with a current or prior malignancy: • Bone pain • Rising tumor markers • Elevated alkaline phosphatase	• Bone scan (CPT® 78306) supplemented by plain x-rays

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Indication	Medically Necessary Imaging Study
ANY of the following in individuals with suspected bone (non-vertebral) metastases: • Bone scan is not feasible or readily available • Bone scan is equivocal or indeterminate • Continued suspicion despite negative/ inconclusive bone scan or other imaging modalities • Soft tissue component suspected on other imaging modalities • Differentiate neoplastic disease from Paget's disease of the bone	EITHER of the following: • MRI without and with contrast of the involved body site • CT without contrast or with contrast of the involved body site
Bone metastases suspected and **both** bone scan and either CT or MRI are inconclusive	• ^{18}F-FDG-PET/CT (CPT® 78815 or CPT® 78816)
EITHER of the following: • No prior cancer history with suspected bone metastatic disease or pathologic fracture on plain x-ray • Adult individuals with a biopsy-proven carcinoma of unknown origin in a bone lesion	• See: **Carcinoma of Unknown Primary Site (ONC-31.7)**

Background and Supporting Information

Bone metastases are the most common malignant lesions of the skeleton, arising from hematogenous spread of tumor cells and occurring more frequently than primary bone tumors, particularly in advanced malignancy (Zhang-Yin & Panagiotidis, 2023; Ahmed et al., 2022). These lesions may be osteolytic, osteoblastic, or mixed, reflecting interactions between tumor cells, osteoblasts, and osteoclasts within the bone microenvironment (Zhang-Yin & Panagiotidis, 2023). The presence of bone metastases is associated with significant morbidity, including skeletal-related events such as pain, fractures, hypercalcemia, and decreased quality of life (Zhang-Yin & Panagiotidis, 2023).

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The likelihood of bone metastases increases with disease progression and recurrence, particularly in malignancies such as breast, prostate, lung, and thyroid cancer, where the skeleton represents a common site of dissemination (Yang et al., 2011; Zhang-Yin & Panagiotidis, 2023). Because metastatic involvement may be multifocal and asymptomatic, imaging plays a central role in detection, staging, and management (Liu et al., 2017; Lombardi et al., 2022).

Evidence Discussion

Bone scintigraphy supplemented by plain radiography is supported as the initial imaging approach in individuals with suspected bone metastases because it provides whole-body evaluation of skeletal involvement and identifies areas of increased osteoblastic activity associated with metastatic disease (Yang et al., 2011; Liu et al., 2017). Bone scan sensitivity is driven by detection of increased bone turnover rather than direct tumor visualization, allowing identification of lesions throughout the skeleton; however, this mechanism also contributes to limited specificity due to overlap with benign processes such as degenerative disease or treatment-related changes (Ahmed et al., 2022; Lombardi et al., 2022). The ability to evaluate the entire skeleton in a single study supports its use as first-line imaging, minimizing the risk of missing multifocal metastatic disease (Yang et al., 2011).

MRI and CT are supported as problem-solving modalities when bone scan findings are equivocal, not feasible, or when clinical suspicion persists despite negative results, as these modalities provide improved anatomic detail and soft tissue characterization (Liu et al., 2017; Di Primio et al., 2023). MRI offers high sensitivity for marrow involvement and is particularly valuable when a soft tissue component is suspected, helping prevent understaging and undertreatment (Lombardi et al., 2022). CT provides detailed evaluation of cortical bone integrity and can assist in differentiating benign from malignant processes, including conditions such as Paget disease, although its overall sensitivity is lower than MRI for early marrow lesions (Qu et al., 2012; Di Primio et al., 2023). This tiered approach balances diagnostic accuracy with appropriate utilization of more resource-intensive imaging.

PET/CT demonstrates variable diagnostic performance depending on tumor histology, reflecting differences in metabolic activity and osteoblastic response across malignancies (Zhang-Yin & Panagiotidis, 2023). While PET techniques, including FDG PET/CT and 18F-NaF PET/CT, can provide high sensitivity for detecting bone metastases, particularly with early marrow involvement or high bone turnover, they are limited by false-positive findings due to benign conditions such as fractures, inflammation, or therapy-induced changes, and may show reduced sensitivity in certain tumor types (Ahmed et al., 2022; Zhang-Yin & Panagiotidis, 2023). Additionally, higher radiation exposure and variability in specificity support restricting PET/CT to a problem-solving role when conventional imaging is inconclusive rather than routine first-line use (Zhang-Yin & Panagiotidis, 2023).

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In individuals without known malignancy but with suspicious bone lesions, systemic imaging with CT of the chest, abdomen, and pelvis or PET/CT is supported to identify a potential primary malignancy, as bone metastases are often secondary to cancers such as breast, prostate, lung, or thyroid (Zhang-Yin & Panagiotidis, 2023; NCCN, 2026). NCCN guidelines support the use of bone scan or PET/CT as part of the diagnostic workup for suspected metastatic disease, emphasizing multimodality imaging to establish diagnosis and guide management (NCCN, 2026). This approach helps ensure appropriate staging and reduces the risk of delayed diagnosis while avoiding unnecessary invasive procedures when imaging can identify a primary source or additional metastatic sites.

Health Equity Considerations

Non-vertebral metastatic bone disease (MBD) represents a common and morbid manifestation of advanced cancer, and substantial health equity gaps influence when and how these lesions are detected and managed. Large population-based analyses demonstrate consistent sex, racial/ethnic, and socioeconomic disparities in the incidence of MBD at cancer diagnosis, particularly for lung, prostate, breast, renal, and colorectal primaries (Jawad et al., 2023). Patients from lower socioeconomic strata and certain racial and ethnic minority groups, especially Non-Hispanic Black and American Indian/Alaska Native populations, present with bone metastases at higher rates, suggesting delayed diagnosis of primary malignancy, limited access to screening, and barriers to timely imaging and oncologic care (Jawad et al., 2023). Because appendicular skeletal metastases often serve as an early indicator of disseminated disease, inequities in access to diagnostic imaging and orthopedic oncology evaluation may lead to higher rates of pathologic fracture, unplanned hospitalizations, and worse functional outcomes in socially disadvantaged populations (Jawad et al., 2023; DiCaprio et al., 2022).

These disparities are compounded by the significant economic and psychosocial burden associated with non-vertebral skeletal-related events, including fractures of the long bones and pelvis. Metastatic bone disease accounts for a substantial proportion of overall cancer care costs and is associated with loss of mobility, diminished quality of life, caregiver strain, and financial hardship, effects that disproportionately impact patients with fewer social and financial resources (DiCaprio et al., 2022). Early identification of appendicular bone metastases through appropriate imaging can facilitate prophylactic interventions, reduce fracture risk, and lower downstream costs, yet timely imaging is not uniformly accessible across populations (DiCaprio et al., 2022; Jawad et al., 2023). Standardized, evidence-based recommendations for imaging of suspected non-vertebral bone metastases support more equitable care by promoting consistent evaluation regardless of sex, race/ethnicity, or socioeconomic status. Guideline-directed imaging helps reduce variability in diagnostic pathways, supports earlier multidisciplinary intervention, and may mitigate preventable morbidity

associated with advanced metastatic bone disease in historically underserved groups (Jawad et al., 2023; DiCaprio et al., 2022).

Oncology Imaging Guidelines

Spinal/Vertebral Metastases (ONC-31.6)

ON.UP.0031.6.A
v1.0.2027

Criteria

- Individuals with stage IV cancer with new onset back pain can forgo a bone scan (and plain films) in lieu of an MRI with and without contrast of the spine.

Indication	Medically Necessary Imaging Study
Individuals 40 years of age or older with no history of malignancy who have a symptomatic bone lesion seen on x-ray and malignancy is suspected	EITHER of the following: • CT Chest with contrast (CPT® 71260), CT Abdomen and Pelvis with contrast (CPT® 74177), and Bone scan (CPT® 78306) OR • FDG PET/CT (CPT® 78815 or CPT® 78816)
Known cancer history and spinal cord compression suspected based on signs/ symptoms of neurological compromise, including, but not limited to: • Unexpected, sudden loss of bowel or bladder control • Sudden loss of ability to ambulate • Complete loss of pinprick sensation corresponding to a specific vertebral level • Loss of pain at a site that had previously been refractory to pain management	MRI Cervical (CPT® 72156), MRI Thoracic (CPT® 72157), and MRI Lumbar Spine (CPT® 72158) without and with contrast OR without contrast (CPT® 72141, CPT® 72146, or CPT® 72148) • CT Cervical (CPT® 72126), CT Thoracic (CPT® 72129), and CT Lumbar (CPT® 72132) Spine with contrast if MRI is contraindicated

Indication	Medically Necessary Imaging Study
Individual with a known history of cancer and ANY of the following: • Metastatic or stage IV cancer with new or worsening back pain • Continued suspicion despite negative/ inconclusive bone scan or other imaging modalities • Back pain and suspicion of spinal malignancy based on any one of the following: ◦ Night pain ◦ Age greater than 70 years ◦ Uncontrolled or unintentional weight loss ◦ Pain unrelieved by change in position ◦ Severe or worsening spinal pain	ONE of the following: • MRI of the relevant spinal level without contrast • MRI of the relevant spinal level without and with contrast • CT of the relevant spinal level without contrast • CT Myelogram of the relevant spinal level
Monitoring untreated vertebral metastases	One of the following, every 3 months for 1 year: • MRI without and with contrast of the involved spinal level • CT without or with contrast of the involved spinal level **Imaging beyond 1 year is based on any new clinical signs/symptoms
Monitoring metastases within the spine treated with surgery and/or radiation therapy	One of the following, once within 3 months post-treatment, and then every 3 months for 1 year: • MRI without and with contrast of the involved spinal level • CT without or with contrast of the involved spinal level **Imaging beyond 1 year is based on any new clinical signs/symptoms

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Indication	Medically Necessary Imaging Study
Leptomeningeal involvement with cancer	Suspected: • MRI Brain without and with contrast (CPT® 70553) and MRI Cervical (CPT® 72156), Thoracic (CPT® 72157), and Lumbar spine (CPT® 72158) without and with contrast • CT Cervical (CPT® 72127), Thoracic (CPT® 72130), and Lumbar Spine (CPT® 72133) without and with contrast is medically necessary if MRI is contraindicated or not readily available On active treatment: • MRI Brain without and with contrast (CPT® 70553) and MRI Cervical (CPT® 72156), Thoracic (CPT® 72157), and Lumbar spine (CPT® 72158) without and with contrast every 2 cycles • CT without or with contrast of the involved spinal level if MRI is contraindicated Once treatment completed: • Routine advanced imaging is not consideredmedically necessary for surveillance in asymptomatic individuals

Background and Supporting Information

Spinal/vertebral metastases most commonly arise from hematogenous dissemination of systemic malignancies to the vertebral column and may extend into the epidural space, resulting in compression of neural structures including the spinal cord (Lawton et al., 2019). Metastatic spinal cord compression (MSCC) is a potentially catastrophic complication of advanced cancer associated with progressive neurologic decline, impaired mobility, and reduced quality of life, and is considered an oncologic emergency requiring prompt diagnosis and intervention (Lawton et al., 2019).

Clinical manifestations vary depending on the level and extent of disease but commonly include back pain, which is reported in up to 80–95% of cases, as well as motor weakness, sensory deficits, and later bowel or bladder dysfunction (Lawton et al., 2019). The presence of neurologic deficits reflects compression of the spinal cord or nerve

roots and may indicate advanced disease, with symptoms localizing variably depending on the affected spinal segment (Lawton et al., 2019).

Evidence Discussion

In individuals 40 years of age or older without a known history of malignancy who present with a symptomatic bone lesion on x-ray with suspicion for malignancy, systemic imaging is supported to identify a primary malignancy and evaluate for metastatic disease. Cross-sectional imaging with CT of the chest, abdomen, and pelvis in combination with bone scintigraphy enables whole-body evaluation of potential primary tumor sites and skeletal involvement, while FDG PET/CT provides an alternative whole-body modality for identifying metabolically active primary and metastatic disease (Expert Panel on Neurologic Imaging, 2019; Lawton et al., 2019). This approach ensures comprehensive staging and reduces the risk of missed systemic disease when spinal involvement may represent the first manifestation of malignancy.

MRI of the spine without and with contrast is supported as the primary imaging modality for suspected spinal/vertebral metastases and spinal cord compression because of its high sensitivity and specificity for detecting epidural disease, marrow infiltration, and neural compression (Lawton et al., 2019). MRI provides superior soft tissue contrast and multiplanar capability, enabling accurate localization of disease and evaluation of the extent of spinal involvement, which is critical for treatment planning (Expert Panel on Neurological Imaging, 2021). In cases of suspected malignant spinal cord compression, imaging of the entire spine is supported due to the presence of multiple, noncontiguous levels of disease in approximately 20–35% of individuals, reducing the risk of missed lesions (Lawton et al., 2019).

MRI is also supported for individuals with known malignancy and new or worsening back pain, even in the absence of overt neurological deficits, as early detection of spinal metastases or impending cord compression may prevent irreversible neurologic injury (Lawton et al., 2019). Compared with CT, MRI provides superior assessment of spinal cord involvement, epidural extension, and marrow disease, whereas CT is limited primarily to evaluation of osseous structures and has lower sensitivity for soft tissue disease (Expert Panel on Neurological Imaging, 2021). Therefore, CT is generally reserved for cases where MRI is contraindicated or unavailable, supporting a risk-based imaging hierarchy consistent with the clinical criteria (Expert Panel on Neurologic Imaging, 2019).

Ongoing imaging surveillance with MRI or CT following treatment is supported to assess response, detect progression, and evaluate complications such as recurrent cord compression or leptomeningeal spread (Lawton et al., 2019). MRI is particularly valuable in this setting due to its ability to detect soft tissue changes, edema, and recurrent disease, while CT may be used when MRI is contraindicated (Expert Panel on Neurological Imaging, 2021). This structured approach to imaging balances early

detection of clinically significant disease with avoidance of unnecessary imaging, consistent with the clinical criteria emphasizing symptom-driven evaluation and appropriate modality selection.

Health Equity Considerations

Spinal and vertebral metastases are a frequent and morbid complication of advanced cancer, often presenting with pain, pathologic fracture, or spinal cord compression that requires urgent, multidisciplinary care. Despite advances in surgical techniques, radiation therapy, and integrated spine oncology programs, substantial disparities persist in access to timely intervention and clinical outcomes. Large systematic and population-based analyses demonstrate that Black patients, those with Medicaid or no insurance, and individuals from lower socioeconomic backgrounds are less likely to receive surgical intervention for metastatic spine disease and more likely to present with advanced neurologic compromise, experience perioperative complications, prolonged hospitalizations, and non-routine discharge dispositions compared with White or privately insured patients (Ehioghae et al., 2025). Hospital-level factors further compound these inequities, as socially disadvantaged patients are disproportionately treated at low-volume or non-teaching institutions, which are associated with higher complication rates and mortality in spine oncology (Ehioghae et al., 2025).

Equity gaps are also reinforced by limitations in the evidence base guiding spinal metastases management. A recent analysis of North American clinical trials revealed marked underreporting of race, ethnicity, and socioeconomic variables, with substantial underrepresentation of racial and ethnic minority groups and complete absence of socioeconomic data in most trials (Bangash et al., 2025). This lack of inclusive reporting limits the generalizability of trial findings and may perpetuate disparities by informing practice guidelines that do not fully reflect the populations most affected by metastatic spine disease. Standardized, evidence-based imaging recommendations for suspected spinal and vertebral metastases support health equity by promoting consistent evaluation regardless of race, insurance status, or socioeconomic position. Guideline-directed imaging facilitates earlier diagnosis, timely referral to multidisciplinary spine oncology teams, and more equitable access to surgical or radiotherapeutic interventions, helping to mitigate preventable neurologic morbidity among historically underserved populations (Ehioghae et al., 2025; Bangash et al., 2025).

Carcinoma of Unknown Primary Site (ONC-31.7)

ON.UP.0031.7.C
v1.0.2027

Criteria

- This guideline also applies to a pathologic fracture that is clearly due to metastatic neoplastic disease in an individual without a previous cancer history.
- Detailed history and physical examination including pelvic and rectal exams and laboratory tests to be performed before advanced imaging.
- Individuals presenting with a thoracic squamous cell carcinoma described as metastatic appearing on chest imaging, or in lymph nodes above the clavicle, should undergo a detailed head and neck examination by a clinician skilled in laryngeal and pharyngeal examinations, especially in smokers.
- Individuals with suspected unknown primary based on only suspicious lytic bone lesions should be considered for serum protein electrophoresis (SPEP), urine protein electrophoresis (UPEP), and serum free light chains prior to consideration of extensive imaging.

Indication	Medically Necessary Imaging Study
Carcinoma found in a lymph node or in an organ known not to be primary	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • CT Neck with contrast (CPT® 70491) if cervical or supraclavicular involvement • CT with contrast or MRI without and with contrast of any other symptomatic site • For individuals assigned female at birth: ◦ Diagnostic (not screening) mammogram and full pelvic exam ◦ MRI Breast Bilateral (CPT® 77049) if pathology consistent with breast primary and mammogram is inconclusive
Sebaceous carcinoma of the skin (can be associated with underlying primary malignancy)	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • CT Neck with contrast (CPT® 70491) if cervical or supraclavicular involvement • CT with contrast or MRI without and with contrast of any other symptomatic site

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Indication	Medically Necessary Imaging Study
Axillary adenocarcinoma	• Diagnostic (not screening) mammogram and full pelvic exam as indicated • MRI Breast Bilateral (CPT® 77049) if pathology consistent with breast primary and mammogram is inconclusive • If the above are non-diagnostic for primary site: ◦ CT Neck (CPT® 70491), CT Chest (CPT® 71260), and CT Abdomen (CPT® 74160) with contrast ◦ CT with contrast or MRI without and with contrast of any other symptomatic site
EITHER of the following: • Carcinoma found within a bone lesion • Unexplained pathologic fracture	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177) • Bone Scan (CPT® 78306) • CT with contrast or MRI without and with contrast of any symptomatic site
ANY of the following: • Above studies have failed to demonstrate site of primary • CT scans reveal isolated metastatic disease for which definitive curative therapy is planned	• PET/CT (CPT® 78815 or CPT® 78816)
Post-treatment surveillance	• Follow-up with CT Chest (CPT® 71260), CT Abdomen and Pelvis (CPT® 74177), and CT of any other involved areas every 6-12 months for 5 years

Background and Supporting Information

Carcinoma of unknown primary (CUP) refers to histologically confirmed metastatic malignancy identified in a lymph node or organ that is not the expected site of origin for the tumor type, where the primary tumor remains unidentified after standard evaluation (NCCN, 2026). CUP represents a heterogeneous group of cancers characterized by early dissemination, unpredictable metastatic patterns, and aggressive clinical behavior (NCCN, 2026). Common sites of involvement include lymph nodes, liver, lung, bone, and brain, reflecting widespread disease at presentation (NCCN, 2026).

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CUP most commonly occurs in older adults and accounts for approximately 2%–9% of all malignancies, with a median survival of approximately 8–12 months, although a subset of patients demonstrates more favorable outcomes based on clinical and pathologic features (NCCN, 2026). Prognosis is influenced by factors including tumor histology, number and sites of metastases, and performance status, with disseminated disease generally associated with poor outcomes (NCCN, 2026; Ren et al., 2023). Bone metastases of unknown origin are associated with particularly poor survival, with reported 1-year survival rates of approximately 15% (Ren et al., 2023).

Evidence Discussion

Cross-sectional imaging with CT of the chest, abdomen, and pelvis is supported as the primary imaging modality in the evaluation of CUP because it provides comprehensive assessment of common primary tumor sites and metastatic disease burden (NCCN, 2026). This approach allows identification of clinically significant disease distribution and guides further targeted imaging or biopsy, supporting accurate staging while minimizing unnecessary imaging. However, CT has limitations in detecting small or early primary tumors, particularly in anatomically complex regions, and may not identify all potential primary sites (NCCN, 2026; Bansal et al., 2022).

Additional site-directed imaging with CT or MRI is supported when symptoms or clinical findings localize disease, as these modalities provide improved anatomic detail and tissue characterization (NCCN, 2026). MRI is particularly useful for evaluating soft tissue involvement and specific organ systems, while CT remains valuable for evaluation of thoracic and abdominal structures. This targeted imaging approach improves diagnostic yield while limiting unnecessary imaging of uninvolved regions, balancing diagnostic accuracy with resource utilization (Sivakumaran et al., 2024).

In individuals with carcinoma involving bone lesions or unexplained pathologic fractures, the addition of bone scintigraphy is supported to evaluate the extent of skeletal disease and identify additional metastatic sites (NCCN, 2026). Bone metastases are common in CUP and are associated with poor prognosis, highlighting the importance of whole-skeleton evaluation to guide staging and management decisions (Ren et al., 2023). Morphologic patterns of bone involvement may also provide indirect clues regarding the potential primary tumor, although specificity remains limited.

PET/CT is supported as a problem-solving modality when conventional imaging fails to identify a primary site or when isolated metastatic disease is identified and definitive therapy is planned (NCCN, 2026). Evidence demonstrates that PET/CT can detect primary tumors in a subset of CUP patients, but its diagnostic performance is variable and associated with intermediate specificity, with potential for false-positive findings (Sivakumaran et al., 2024; Bansal et al., 2022). Therefore, restricting PET/CT to selected clinical scenarios helps optimize its diagnostic benefit while minimizing unnecessary imaging, cost, and downstream interventions.

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Health Equity Considerations

Carcinoma of unknown primary (CUP) represents a diagnostically complex and clinically aggressive entity, with persistently poor outcomes despite advances in imaging and pathologic evaluation. Population-based analyses demonstrate substantial socioeconomic and racial disparities in both the diagnosis and survival of patients with CUP. Data from the Surveillance, Epidemiology, and End Results (SEER) program indicate that CUP is disproportionately diagnosed among older adults, Black patients, women, and individuals residing in less affluent or less educated communities, with these groups also less likely to undergo histologic confirmation of disease (Urban et al., 2013). Median survival remains approximately three months overall, with significantly worse outcomes observed among Black patients and those from socioeconomically disadvantaged areas, even after adjustment for clinical and demographic factors (Urban et al., 2013). These findings suggest that inequities in access to timely and comprehensive diagnostic evaluation, including advanced imaging, contribute meaningfully to observed disparities in staging accuracy, initiation of therapy, and survival.

Equity gaps in CUP care are further reinforced by differential access to modern diagnostic resources. Urban et al. (2013) demonstrated that patients from poorer or less educated regions were less likely to receive adequate diagnostic workup, including pathologic confirmation, and that such limitations were associated with markedly shorter survival. Given that improvements in imaging modalities, including cross-sectional imaging and PET/CT, have been central to reducing the proportion of cancers classified as CUP, inconsistent access to these tools risks perpetuating disparities by delaying identification of a treatable primary malignancy or appropriate site-directed therapy (Urban et al., 2013). Standardized, guideline-directed imaging pathways for suspected CUP can help mitigate these inequities by promoting consistent diagnostic evaluation regardless of race, age, or socioeconomic status, supporting earlier diagnosis, more accurate classification, and more equitable access to subsequent oncologic management.

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Extrathoracic Small Cell and Large Cell Neuroendocrine Tumors (ONC-31.8)

ON.UP.0031.8.C
v1.0.2027

Criteria

- All poorly-differentiated small cell and large cell neuroendocrine tumors arising outside the lungs or of unknown primary origin are imaged according to these guidelines.
- For intrathoracic poorly differentiated neuroendocrine cancer, see: **Small Cell Lung Cancer (ONC-7)**

Indication	Medically Necessary Imaging Study
Initial staging of extrathoracic small cell and large cell neuroendocrine tumors	ONE of the following combinations: • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • CT Chest with contrast (CPT® 71260) and MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)
Inconclusive findings on conventional imaging studies in individuals with extrathoracic small cell and large cell neuroendocrine tumors	• PET/CT (CPT® 78815)

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Indication	Medically Necessary Imaging Study
ANY of the following in individuals with extrathoracic small cell and large cell neuroendocrine tumors: • Poorly differentiated neuroendocrine cancers of the head or neck • Signs or symptoms of CNS involvement	• MRI Brain without and with contrast (CPT® 70553)
Restaging during treatment in individuals with extrathoracic small cell and large cell neuroendocrine tumors	ONE of the following combinations, every 2 cycles: • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) and any CT of known sites of disease with contrast • CT Chest with contrast (CPT® 71260) and MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) and CT with contrast of any known sites of disease
Suspected Recurrence in individuals with extrathoracic small cell and large cell neuroendocrine tumors	ANY or ALL of the following are medically necessary: • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast or CT Chest with contrast (CPT® 71260) and MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197) • MRI Brain without and with contrast (CPT® 70553) • Bone scan (CPT® 78306) • PET imaging is generally **not** considered medically necessary but can be considered for rare circumstances.

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Indication	Medically Necessary Imaging Study
Surveillance in individuals with extrathoracic small cell and large cell neuroendocrine tumors	ONE of the following combinations every 3 months for 1 year, then every 6 months: • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • CT Chest with contrast (CPT® 71260) and MRI Abdomen without and with contrast (CPT® 74183) and MRI Pelvis without and with contrast (CPT® 72197)

Background and Supporting Information

Poorly differentiated neuroendocrine neoplasms (NENs), including small cell and large cell neuroendocrine carcinomas, are aggressive epithelial malignancies that can arise in multiple extrathoracic sites, including the gastrointestinal tract and pancreas, and are distinct from well-differentiated neuroendocrine tumors in both biology and prognosis (Kaewput et al., 2022; NCCN, 2025). These tumors are characterized by high proliferative activity and rapid progression, with a marked propensity for early metastatic spread, particularly to the liver, lymph nodes, bone, and central nervous system (NCCN, 2025).

Tumor grade is a critical determinant of imaging behavior and prognosis. High-grade neuroendocrine carcinomas are associated with increased metabolic activity, poorer outcomes, and a higher likelihood of systemic dissemination, necessitating comprehensive staging and interval reassessment during treatment and follow-up (Kaewput et al., 2022; NCCN, 2025).

Evidence Discussion

Contrast-enhanced CT of the chest, abdomen, and pelvis is supported as the primary imaging modality for initial staging and restaging of poorly differentiated extrathoracic neuroendocrine carcinomas because it provides high sensitivity for detection of primary and metastatic disease and allows comprehensive anatomic evaluation (Kaewput et al., 2022; Poltorak-Szymczak et al., 2021). Reported diagnostic performance demonstrates sensitivity and specificity ranging from approximately 82%–100% for cross-sectional imaging, supporting its use as first-line evaluation (Kaewput et al., 2022). MRI is an appropriate alternative for abdominal and pelvic evaluation, offering improved sensitivity for hepatic and bone marrow metastases, but both modalities primarily assess anatomic changes and may have limitations in detecting small or early lesions (Kaewput et al., 2022; Poltorak-Szymczak et al., 2021).

FDG PET/CT is not supported as routine first-line imaging in poorly differentiated neuroendocrine tumors due to variability in diagnostic performance and lack of

consistent superiority over conventional imaging; however, it provides important complementary metabolic information and is useful as a problem-solving modality when conventional imaging is inconclusive (Kaewput et al., 2022; NCCN, 2025). FDG PET is more sensitive in high-grade tumors because of increased glycolytic activity, and positive uptake correlates with aggressive biology, poorer prognosis, and shorter progression-free and overall survival (Kaewput et al., 2022). Despite this, variability in sensitivity and lack of standardized thresholds support limiting its use to selected clinical scenarios rather than routine staging.

MRI of the brain is supported in individuals with poorly differentiated neuroendocrine carcinomas of the head and neck or when there are signs or symptoms of central nervous system involvement, as these tumors have a recognized risk of CNS metastases (NCCN, 2025). MRI provides superior sensitivity for detection of brain metastases compared with CT and allows early identification of clinically significant disease, supporting timely intervention and improved neurologic outcomes (NCCN, 2025).

Serial cross-sectional imaging during treatment and surveillance is supported due to the aggressive nature and high recurrence risk of poorly differentiated neuroendocrine carcinomas (NCCN, 2025). Repeating imaging at defined intervals allows assessment of treatment response and early detection of disease progression or recurrence. Although PET imaging is not routinely recommended for surveillance, selective use may be considered in rare circumstances where additional metabolic characterization may influence management, balancing diagnostic benefits with cost and potential for false-positive findings (Kaewput et al., 2022; NCCN, 2025).

Oncology Imaging Guidelines

Primary Peritoneal Mesothelioma (ONC-31.9)

ON.UP.0031.9.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Initial staging in individuals with primary peritoneal mesothelioma	• CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • PET/CT (CPT® 78815) if there is no evidence of metastatic disease or conventional imaging is inconclusive
Recurrence/ Restaging in individuals with primary peritoneal mesothelioma	• If there is known prior disease, CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • PET for inconclusive finding on conventional imaging
Surveillance in individuals with primary peritoneal mesothelioma	• CT Abdomen and Pelvis with contrast (CPT® 74177) every 3-6 months for 5 years, then annually until year 10

Background and Supporting Information

Primary malignant peritoneal mesothelioma (PPM) is a rare and aggressive malignancy arising from mesothelial cells lining the peritoneum, accounting for approximately 10%–15% of all mesotheliomas (Acs et al., 2022; NCCN, 2026). The disease is characterized by diffuse peritoneal involvement, extensive intraperitoneal tumor spread, and relatively limited hematogenous dissemination, with most disease burden confined to the abdominal cavity (Acs et al., 2022). PPM is associated with significant morbidity and mortality, and prognosis is generally poor, particularly in advanced-stage disease (Ma & Zhang, 2022).

PPM most commonly presents at an advanced stage due to nonspecific clinical symptoms and lack of early disease markers, contributing to delays in diagnosis

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(Ma & Zhang, 2022; Acs et al., 2022). Histologic classification includes epithelioid, sarcomatoid, and biphasic subtypes, with significant prognostic implications, as epithelioid histology is associated with more favorable outcomes (Ma & Zhang, 2022; NCCN, 2026). Tumor burden and disease distribution are commonly assessed using the peritoneal cancer index (PCI), which correlates with stage and prognosis (Acs et al., 2022).

Treatment strategies are guided by disease extent and patient factors, with cytoreductive surgery combined with hyperthermic intraperitoneal chemotherapy (HIPEC) representing the primary treatment modality for eligible patients and associated with improved survival outcomes compared to historical treatment approaches (Acs et al., 2022; NCCN, 2026). Imaging is therefore essential for staging, assessing operability, and monitoring disease course.

Evidence Discussion

Contrast-enhanced CT of the chest, abdomen, and pelvis is supported as the primary imaging modality for initial staging and restaging of primary peritoneal mesothelioma because it provides comprehensive assessment of disease distribution, including peritoneal involvement, lymphadenopathy, and potential metastatic disease (NCCN, 2026). PPM typically presents with diffuse intraperitoneal tumor spread, and CT allows evaluation of tumor burden and confirmation that disease is not secondary to another primary malignancy (Acs et al., 2022). CT also enables assessment of common sites of spread, including local lymph nodes and pleural extension, which are more frequent than distant metastases (Acs et al., 2022).

CT imaging is favored over MRI for routine staging and restaging due to its overall higher sensitivity for this disease process and ability to evaluate the entire thoracoabdominal cavity in a single examination (NCCN, 2026). MRI may be used as a complementary modality for further characterization of indeterminate lesions, particularly within the liver, but is not routinely used as first-line imaging (NCCN, 2026). This imaging hierarchy supports accurate staging while minimizing unnecessary additional imaging and resource utilization.

PET/CT demonstrates variable sensitivity in PPM, with reported ranges from approximately 58% to 100%, reflecting heterogeneity in tumor biology and metabolic activity (NCCN, 2026). Because of this variability, PET/CT is not supported as a primary staging modality but may provide incremental value by detecting small peritoneal implants or occult disease not visualized on conventional imaging, which may alter management decisions (NCCN, 2026). Use of PET/CT in this selective manner reduces the risk of both under-staging and overutilization of advanced imaging.

For surveillance and post-treatment monitoring, routine cross-sectional imaging is supported due to the high risk of recurrence, particularly within the first several years following treatment (Acs et al., 2022; NCCN, 2026). Frequent imaging in the early post-

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treatment period is justified by the high rate of recurrence, with a majority of recurrences occurring within the first few years, while longer-term follow-up remains necessary due to the potential for late recurrence (Acs et al., 2022). This structured imaging approach balances early detection of clinically significant recurrence with avoidance of excessive imaging over time.

Health Equity Considerations

Primary peritoneal mesothelioma (PPM) is a rare and aggressive malignancy characterized by nonspecific clinical manifestations, frequently resulting in delayed diagnosis and advanced disease at presentation. Population-based analyses demonstrate that PPM predominantly affects older adults and is more commonly diagnosed in male and White patients; however, women comprise a substantial proportion of cases compared with pleural mesothelioma, suggesting differing exposure patterns and diagnostic pathways (Ullah et al., 2022; Dusseault et al., 2022). The insidious onset of symptoms such as ascites and abdominal pain, coupled with historically high rates of undefined histology and late-stage disease in registry data, underscores persistent inequities in timely recognition and comprehensive diagnostic evaluation, including imaging-based disease characterization (Ullah et al., 2022; Calthorpe et al., 2023). Limited awareness of paraoccupational asbestos exposure and variable access to advanced cross-sectional imaging may further contribute to delays in diagnosis among socioeconomically and geographically disadvantaged populations (Dusseault et al., 2022; Karpes et al., 2023).

Health system-level factors also play a significant role in outcome disparities for PPM. Evidence indicates that survival improvements over time are closely linked to accurate histologic classification and access to cancer-directed surgery, including cytoreductive surgery with hyperthermic intraperitoneal chemotherapy, which are typically available only at specialized, high-volume centers (Calthorpe et al., 2023; Karpes et al., 2023). Patients without access to these centers may experience incomplete staging, limited imaging surveillance, or receipt of non-definitive therapies, exacerbating existing disparities. Given the central role of contrast-enhanced CT, and, in selected cases, MRI or PET, in defining disease extent, operability, and treatment response, consistent application of evidence-based imaging recommendations supports health equity by promoting uniform diagnostic evaluation and facilitating appropriate referral regardless of sex, race, socioeconomic status, or geographic location (Ullah et al., 2022; Karpes et al., 2023).

Kaposi's Sarcoma (ONC-31.10)

ON.UP.0031.10.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Kaposi's Sarcoma	• Advanced imaging is not considered medically necessary since disease is generally localized to skin. • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast at initial diagnosis. If initial scans are negative then future imaging would be based on signs or symptoms.

Background and Supporting Information

Kaposi sarcoma (KS) is a multifocal endothelial malignancy associated with infection by Kaposi sarcoma–associated herpesvirus (KSHV/HHV-8), and is characterized by cutaneous, mucosal, and, less commonly, visceral involvement. KS presents classically with purpuric, red, or brown macules, papules, or plaques and may occur in several clinical forms, including HIV-associated, classic, iatrogenic (transplant-associated), and endemic disease. Immunosuppression plays a central role in pathogenesis, with increased incidence and more aggressive disease observed in individuals with impaired immune function, particularly those with HIV infection (NCCN, 2025).

Disease extent in KS varies from limited cutaneous involvement to advanced disease affecting lymph nodes, viscera, or mucosal surfaces, with staging based on tumor burden, immune status, and systemic disease factors. Most cases are confined to the skin and subcutaneous tissues; however, visceral involvement may occur, particularly in advanced or immunosuppressed states. The clinical course is influenced by immune status and disease distribution, and management strategies are guided by the extent of disease and associated symptoms (NCCN, 2025).

Evidence Discussion

Kaposi sarcoma is most commonly localized to the skin, and therefore routine advanced imaging is not supported in asymptomatic individuals without evidence of visceral involvement, as the diagnostic yield is low and clinical examination is generally sufficient for disease evaluation. Limiting imaging in this population reduces unnecessary radiation exposure, cost, and incidental findings that may lead to additional testing, while maintaining appropriate clinical management based on physical examination and symptom assessment (NCCN, 2025).

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CT of the chest, abdomen, and pelvis with contrast at initial diagnosis is supported to evaluate for visceral disease, which may not be clinically apparent, particularly in individuals with HIV-associated or advanced disease. This approach helps prevent under-staging and ensures appropriate identification of patients who may require systemic therapy, as visceral or nodal involvement is associated with more advanced disease and different management strategies. However, because visceral involvement is not present in the majority of cases, imaging is limited to initial staging rather than routine repeated evaluation in all patients (NCCN, 2025).

Subsequent imaging is appropriately guided by signs or symptoms suggestive of new or progressive visceral involvement, as clinical changes such as gastrointestinal or pulmonary symptoms may indicate disease progression beyond cutaneous sites. This symptom-directed approach balances the need for detection of clinically significant disease with avoidance of unnecessary imaging, particularly given that KS lesions may wax and wane and are often monitored clinically (NCCN, 2025).

There is no evidence supporting routine surveillance imaging in Kaposi sarcoma in the absence of symptoms or known visceral disease, as recurrence or progression is frequently detected clinically and ongoing imaging may contribute to patient burden without improving outcomes. Instead, follow-up relies on clinical evaluation and monitoring of disease extent, with imaging reserved for cases where new clinical findings raise concern for internal disease involvement or complications (NCCN, 2025).

Health Equity Considerations

Kaposi's sarcoma (KS) is an angioproliferative malignancy strongly linked to human herpesvirus-8 infection and immunosuppression, most commonly in the setting of HIV. Although the widespread adoption of combination antiretroviral therapy (ART) has led to substantial declines in KS incidence and mortality in the United States, these improvements have not been equitably distributed. Large population-based analyses demonstrate persistent and pronounced racial, sex-based, and geographic disparities, with Black men experiencing substantially higher incidence and mortality rates than White men, particularly in the Southern United States (Royse et al., 2017; Raja et al., 2025). Black patients are more likely to be diagnosed at younger ages and with more advanced disease, reflecting inequities in HIV prevention, testing, linkage to care, and sustained viral suppression rather than biologic differences alone (Anthony et al., 2023; Raja et al., 2025). These disparities directly affect patterns of diagnostic imaging, as delayed presentation may necessitate more extensive baseline evaluation to assess visceral, pulmonary, or nodal involvement.

Structural and health-system factors further reinforce inequities in KS outcomes and imaging utilization. Lower rates of ART adherence, higher levels of medical mistrust, underinsurance, and limited access to subspecialty HIV-oncology care among marginalized populations contribute to delayed diagnosis, fragmented staging,

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and inconsistent longitudinal assessment (Anthony et al., 2023; Royse et al., 2017). Geographic disparities are particularly evident in the U.S. South, where higher regional HIV burden and reduced access to comprehensive care are associated with increasing KS incidence among Black men despite national downward trends (Royse et al., 2017; Raja et al., 2025). Given the role of imaging in detecting extracutaneous disease, guiding treatment selection, and monitoring response, consistent application of evidence-based imaging recommendations supports health equity by promoting timely and standardized evaluation regardless of race, sex, or geographic location, and by facilitating appropriate escalation of care for populations at greatest risk of advanced or multisystem disease.

Oncology Imaging Guidelines

Castleman's Disease (Unicentric and Multicentric) (ONC-31.11)

ON.UP.0031.11.A
v1.0.2027

Criteria

Indication	Medically Necessary Imaging Study
Initial staging in individuals with Castleman's Disease	• Either CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast **or** PET/CT (CPT® 78815) • CT Neck with contrast (CPT® 70491) if cervical or supraclavicular involvement • If CT scans were utilized initially and suggested unicentric disease, and surgical resection is being considered, PET/CT (CPT® 78815) can be approved to confirm unicentric disease • If unicentric disease is surgically removed, proceed to surveillance section
Restaging in individuals with Castleman's Disease: • Multicentric disease or surgically unresected unicentric disease on chemotherapy	ONE of the following every 2 cycles: • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • PET/CT (CPT® 78815)
ANY of the following in individuals with Castleman's Disease: • Suspected recurrence • Recurrent B symptoms • Rising LDH/IL-6/ VEGF levels	ONE of the following: • CT Chest (CPT® 71260) and CT Abdomen and Pelvis (CPT® 74177) with contrast • PET/CT (CPT® 78815)

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Indication	Medically Necessary Imaging Study
Surveillance in individuals with Castleman's Disease	• CT with contrast of involved areas no more than every 6 months up to 5 years

Background and Supporting Information

Castleman disease (CD) is a heterogeneous group of lymphoproliferative disorders characterized by abnormal lymph node architecture and variable clinical presentation, and is broadly classified into unicentric CD (UCD) and multicentric CD (MCD) (NCCN, 2026; Dispenzieri & Fajgenbaum, 2020). UCD involves a single lymph node region and is typically localized with an indolent clinical course, whereas MCD involves multiple lymph node regions and is associated with systemic inflammatory symptoms, organ dysfunction, and higher morbidity (NCCN, 2026; Hoffmann et al., 2022).

MCD includes several biologically distinct subtypes, including HHV-8–associated MCD, idiopathic MCD (iMCD), and POEMS-associated MCD, each characterized by differing etiologies and clinical behaviors (NCCN, 2026; Dispenzieri & Fajgenbaum, 2020). Disease manifestations in MCD are driven largely by cytokine dysregulation, particularly interleukin-6, and may include fever, weight loss, cytopenias, organomegaly, and fluid accumulation, with severity ranging from indolent disease to fulminant organ failure (van Rhee et al., 2018; NCCN, 2026).

Evidence Discussion

PET/CT is supported as a primary modality for initial staging of Castleman disease because it provides whole-body evaluation to differentiate unicentric from multicentric disease and allows metabolic characterization of lymphadenopathy (van Rhee et al., 2018; Hoffmann et al., 2022). Standardized uptake values on PET/CT may assist in distinguishing Castleman disease from lymphoma, which is critical in avoiding misclassification and ensuring appropriate treatment selection (van Rhee et al., 2018). However, variability in metabolic activity and overlap with other inflammatory or malignant processes may limit specificity, supporting the use of PET/CT as part of a multimodality assessment rather than a standalone diagnostic tool.

Contrast-enhanced CT of the chest, abdomen, and pelvis is supported as an alternative to PET/CT for initial staging and disease assessment, as it provides detailed anatomic evaluation of lymph node involvement and organ disease (NCCN, 2026; Hoffmann et al., 2022). CT allows identification of localized versus systemic disease and is sufficient for staging in many cases; however, it lacks the functional information provided by PET imaging. Concurrent use of CT and PET/CT is not routinely supported, as it does not significantly change management and may increase radiation exposure and healthcare utilization without added clinical benefit (van Rhee et al., 2018).

In cases where CT suggests unicentric disease and surgical resection is being considered, PET/CT is supported as a confirmatory modality to exclude additional occult sites of disease, thereby preventing under-staging and inappropriate local treatment (NCCN, 2026; Dispenzieri & Fajgenbaum, 2020). This step is particularly important given that treatment differs significantly between unicentric and multicentric disease, with surgery often curative in UCD and systemic therapy required for MCD (NCCN, 2026).

For restaging, surveillance, and evaluation of recurrence, imaging strategies reflect the underlying disease biology. In MCD or unresected UCD undergoing systemic therapy, serial imaging with CT or PET/CT allows monitoring of treatment response and disease progression, including detection of aggressive subtypes such as HHV-8–associated or POEMS-associated MCD (van Rhee et al., 2018; NCCN, 2026). PET/CT is also appropriate for suspected recurrence or for rising biomarkers such as LDH, IL-6, or VEGF, which may indicate active disease. However, for surveillance after treatment, imaging is limited to periodic CT of involved areas, as PET/CT has not demonstrated sufficient incremental benefit in this setting and may increase cost and radiation exposure, aligning with recommendations to avoid routine PET use in surveillance (NCCN, 2026; Hoffmann et al., 2022).

Health Equity Considerations

Castleman disease (CD) is a rare and heterogeneous lymphoproliferative disorder that includes clinically distinct entities such as unicentric Castleman disease (UCD) and idiopathic multicentric Castleman disease (iMCD). Health equity challenges in CD primarily stem from its rarity, protean clinical manifestations, and reliance on advanced diagnostic resources, which contribute to delayed or missed diagnoses across diverse populations. Large multicenter and registry-based studies demonstrate that iMCD frequently presents with systemic inflammation, cytopenias, organomegaly, effusions, and multiorgan dysfunction, often necessitating extensive imaging to establish disease extent and exclude mimicking malignancies (Bustamante et al., 2024; Liu et al., 2022). Diagnostic delays are particularly likely in settings with limited access to subspecialty hematopathology, cross-sectional imaging, and multidisciplinary care, disproportionately affecting patients in resource-constrained or underserved healthcare systems. International cohort data further suggest variation in outcomes by geography and ethnicity, with inferior survival observed in some non-U.S. populations, highlighting the potential impact of systemic differences in access to timely diagnosis, imaging, and disease-directed therapy (Liu et al., 2022).

These inequities have direct implications for imaging utilization in CD. Imaging plays a central role in differentiating unicentric from multicentric disease, assessing extranodal involvement, identifying complications such as serous effusions or organomegaly, and monitoring response to therapy, particularly in iMCD where disease burden and flare activity can be substantial (Bustamante et al., 2024). Patients with severe subtypes

such as iMCD-TAFRO experience high hospitalization rates and require frequent reassessment for progressive organ involvement, underscoring the importance of consistent, guideline-based imaging strategies to avoid under-staging or delayed recognition of complications (Bustamante et al., 2024). Standardized application of evidence-based imaging recommendations supports health equity by promoting uniform diagnostic evaluation and follow-up, regardless of patient demographics or care setting, and by facilitating early disease characterization that can enable timely referral to specialized centers and appropriate therapy for this complex and potentially life-threatening condition (Liu et al., 2022).

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Procedure Codes Associated With Oncology Imaging (ONC)

Guideline Page

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Procedure Codes Associated With Oncology Imaging (ONC)

v1.0.2027

The inclusion of any code in this table does not imply that the code is under management or requires prior authorization. Refer to the applicable health plan for management details. Prior authorization of a code listed in this table is not a guarantee of payment. The Certificate of Coverage or Evidence of Coverage policy outlines the terms and conditions of the member's health insurance policy.

Code	Description
70460	Computed tomography, head or brain; with contrast material(s)
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70486	Computed tomography, maxillofacial area; without contrast material
70487	Computed tomography, maxillofacial area; with contrast material(s)
70490	Computed tomography, soft tissue neck; without contrast material
70491	Computed tomography, soft tissue neck; with contrast material(s)
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)
70543	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences

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Code	Description
71250	Computed tomography, thorax, diagnostic; without contrast material
71260	Computed tomography, thorax, diagnostic; with contrast material(s)
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)
71552	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences
72126	Computed tomography, cervical spine; with contrast material
72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections
72129	Computed tomography, thoracic spine; with contrast material
72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections
72132	Computed tomography, lumbar spine; with contrast material
72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)

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Code	Description
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
72193	Computed tomography, pelvis; with contrast material(s)
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)
74150	Computed tomography, abdomen; without contrast material
74160	Computed tomography, abdomen; with contrast material(s)
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing

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Code	Description
74176	Computed tomography, abdomen and pelvis; without contrast material
74177	Computed tomography, abdomen and pelvis; with contrast material(s)
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation
76390	Magnetic resonance spectroscopy
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation

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Code	Description
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited
76830	Ultrasound, transvaginal
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)
76872	Ultrasound, transrectal
76882	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation
77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation

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Code	Description
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral
77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply
78018	Thyroid carcinoma metastases imaging; whole body
78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)
78104	Bone marrow imaging; whole body
78195	Lymphatics and lymph nodes imaging
78300	Bone and/or joint imaging; limited area
78305	Bone and/or joint imaging; multiple areas
78306	Bone and/or joint imaging; whole body
78315	Bone and/or joint imaging; 3 phase study
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
78800	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single area (eg, head, neck, chest, pelvis), single day imaging

Code	Description
78801	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days
78802	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, single day imaging
78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) , single area (eg, head, neck, chest, pelvis), single day imaging
78804	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, requiring 2 or more days imaging
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh
78813	Positron emission tomography (PET) imaging; whole body
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh

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Code	Description
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/ detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days
78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/ detection of pathology, minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days
78835	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)
93306	Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with Spectral doppler echocardiography, and with color flow doppler echocardiography

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Code	Description
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study
A9515	Choline c-11, diagnostic, per study dose up to 20 millicuries
A9552	Fluorodeoxyglucose f-18 fdg, diagnostic, per study dose, up to 45 millicuries
A9580	Sodium fluoride f-18, diagnostic, per study dose, up to 30 millicuries
A9587	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie
A9588	Fluciclovine f-18, diagnostic, 1 millicurie
A9591	Fluoroestradiol f 18, diagnostic, 1 millicurie
A9592	Copper cu-64, dotatate, diagnostic, 1 millicurie
A9593	Gallium ga-68 psma-11, diagnostic, (ucsf), 1 millicurie
A9594	Gallium ga-68 psma-11, diagnostic, (ucla), 1 millicurie
A9595	Piflufolastat f-18, diagnostic, 1 millicurie
A9596	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie
A9608	Flotufolastat f 18, diagnostic, 1 millicurie
A9616	Gallium ga-68 gozetotide (gozellix), diagnostic, 1 millicurie
A9800	Gallium ga-68 gozetotide, diagnostic, (locametz), 1 millicurie
C9067	Gallium ga-68, dotatoc, diagnostic, 0.01 mci

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