AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Ovarian Cancer

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Malignant neoplasm of the ovary, fallopian tube, or peritoneum — predominantly epithelial in origin, with high-grade serous carcinoma the most common histologic subtype. No validated population screening test exists; approximately 80% of cases are diagnosed at FIGO Stage III or IV.[1] Median age at diagnosis is 63 years.[1]

ICD-10 Codes:

Primary ovary **C56.1** (right)/**C56.2** (left)/**C56.3** (bilateral)/**C56.9** (unspecified — avoid); primary peritoneal **C48.0–C48.8** (distinct entity, **not C56). Metastatic sites: C78.6 peritoneum, C78.7** liver**, C78.0x** lung**, C78.89** omentum/intestine, **C79.31** brain (each maps to HCC 17); **C79.51** bone (HCC 18). Code each metastatic site individually.

Prevalence: ACS projects ~21,010 new diagnoses[2] and ~12,450 deaths[2] in the U.S. in 2026; lifetime risk ~1.3%.[2] Approximately 50% of patients are aged ≥65[3] at diagnosis — the core Medicare population. 5-year relative survival: Stage I 92%; Stage II 72%; Stage III–IV 27%.[4]

HCC/RAF V28 Mapping

ICD-10 CODE[1–3]	HCC CATEGORY	RAF WEIGHT	DOCUMENTATION REQUIREMENT
C56.1, C56.2, C56.3 (Malignant neoplasm of ovary)	HCC 23 — Prostate, Breast, other Cancers and Tumors	0.186	**Primary ovarian cancer** with documented **laterality** from pathology or imaging. **C56.9 reduces specificity** and is discouraged
C78.6, C78.7, C78.0x, C78.89, C79.31 (Secondary malignant neoplasm of respiratory and digestive organs)	HCC 17 — Cancer Metastatic to Lung/Liver/Brain/ Other	4.209	Metastatic spread to **peritoneum, liver, lung, omentum/intestine, or brain**. Each site coded **individually** with imaging or pathologic evidence
C79.51 (Secondary malignant neoplasm of bone)	HCC 18 — Cancer Metastatic to Bone/Other	2.341	**Bone metastasis**; document **specific bone site** (e.g., vertebral, femur) when available
C79.60, C79.61, C79.62 (Secondary malignant neoplasm of other and unspecified sites)	HCC 18 — Cancer Metastatic to Bone/Other	2.341	**Metastasis to the ovary from another primary**; documented laterality preferred

ICD-10 CODE[1–3]	HCC CATEGORY	RAF WEIGHT	DOCUMENTATION REQUIREMENT

ABBREVIATIONS: ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification | HCC = Hierarchical Condition Category | RAF = Risk Adjustment Factor | CNA = Community Non-Dual Eligible, Aged *RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model;11 values vary across patient populations based on eligibility and care setting

Risk-Adjusted Care Resources per Patient/Year

RAF weight × MA base rate = estimated annual care coordination support per documented HCC

Ovarian Cancer
~$3,776
HCC 23 · RAF 0.363 · per active patient/year

Cancer Metastatic to Lung/Liver/Brain/and Other Organs
~$43,783
HCC 17 · RAF 4.209 · per active patient/year

Cancer Metastatic to Bone/Other and Unspecified Metastatic Cancer
~$23,352
HCC 18 · RAF 2.341 · per active patient/year

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

RAF coefficients are CNA segment, 2026 CMS-HCC Model V28. The impact of this condition varies across patient populations, particularly in individuals with disability, dual eligibility, or those receiving care in institutional settings.

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings (older adults, at-risk population)

TEST	COVERAGE	FREQUENCY	CPT CODE	CLINICAL INDICATION
Pelvic/ transabdominal ultrasound	Diagnostic only — Medicare does NOT cover screening	As clinically indicated for symptomatic patients	76856/76830	**Palpable pelvic mass**; ascites; abdominal distention; adnexal mass characterization[5,6]

TEST	COVERAGE	FREQUENCY	CPT CODE	CLINICAL INDICATION
CA-125 serum	Diagnostic only — Medicare does NOT cover screening (USPSTF Grade D)	As clinically indicated; surveillance interval per oncology	86304	Postmenopausal adnexal mass + **CA-125 >35 U/mL**; **RMI>200 -> surgical referral**; rising **CA-125 >25%** above nadir or doubling in 3 months -> progression[7,8]
CT abdomen/pelvis with contrast	Covered when diagnostic	Pre-operative staging; surveillance per NCCN	74177	**Suspected malignancy**; preoperative staging (FIGO I-IV); peritoneal implants; retroperitoneal lymphadenopathy; post-treatment surveillance every **4-6 mos x 2 yrs** then **annually**[9]
BRCA1/2 germline genetic testing	Covered for qualifying patients (NCCN criteria)	Once per lifetime if criteria met	81162/81163 /81164	**All epithelial ovarian/ fallopian tube/peritoneal cancer patients** (any age). PARP inhibitor eligibility[10]

ABBREVIATIONS: USPSTF = U.S. Preventive Services Task Force | CPT = Current Procedural Terminology | NCCN = National Comprehensive Cancer Network | BRCA = BReast CAncer gene | CA-125 = Cancer Antigen 125

Subtle Early Signs in Older Adults (>65)

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Persistent abdominal bloating	New-onset, occurring **>12× per month for <12 months**. In women **>50**, treat as ovarian cancer until proven otherwise — **do not default to IBS or functional GI**[11]
Pelvic or lower abdominal pain	**Persistent** or **progressive pelvic pressure** or **pain** in postmenopausal women warrants imaging **plus CA-125**; pain quality is non-specific but persistence is the signal[11]
Early satiety/unexplained appetite loss	Often **misattributed to age or constipation**. Combination with bloating and pelvic discomfort is the classic ovarian symptom triad[11,12]
Urinary urgency or frequency	Frequency >**12×/month in absence of UTI**; reflects pelvic mass effect on bladder; common but non-specific[11]

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Postmenopausal palpable ovary	**Any palpable ovary in a postmenopausal woman is abnormal**. Imaging and CA-125 indicated regardless of symptoms — the 'postmenopausal palpable ovary' rule[11]

ABBREVIATIONS: IBS = Irritable Bowel Syndrome | UTI = Urinary Tract Infection | GI = Gastrointestinal | CA-125 = Cancer Antigen 125

Geriatric Risk Factors

FACTOR	RISK SIGNAL	NOTES
BRCA1/2 germline mutation	Lifetime risk 20–70% (BRCA1) or 10–27% (BRCA2)[13]	Refer for **genetic counseling** and **risk-reducing salpingo-oophorectomy** discussion. Document Z15.02
Lynch syndrome (MMR variant)	Lifetime risk 5–18%[13]	Co-occurring **colorectal and endometrial cancer** risk; synchronize surveillance
Family history of breast or ovarian cancer	First-degree relative with breast/ovarian cancer (especially <50)	NCCN criteria for **BRCA testing**; document Z80.41 to support coverage
Endometriosis	HR 4.20 (95% CI 3.59–4.91)[14] for ovarian cancer[15]	Long-standing endometriosis is an independent risk factor; **clear-cell and endometrioid histology**

ABBREVIATIONS: BRCA = BReast CAncer gene | MMR = Mismatch Repair | HR = Hazard Ratio | RR = Relative Risk | CI = Confidence Interval | NCCN = National Comprehensive Cancer Network

Diagnostic Thresholds

TEST/MARKER	DIAGNOSIS CRITERION	NOTES
CA-125	≥35 U/mL in postmenopausal women with adnexal mass or persistent symptoms	Sensitivity **~50%** in early-stage disease;[1] **normal CA-125 does NOT** rule out ovarian cancer. Pair with ultrasound
Transvaginal ultrasound	Complex adnexal mass (solid components, thick septations, papillary projections)	First-line imaging. Simple **unilocular cyst <5 cm** in postmenopausal women **generally low-risk**; complex features prompt referral[1,16]

TEST/MARKER	DIAGNOSIS CRITERION	NOTES
Risk of Malignancy Index (RMI)	RMI ≥250 (menopausal score × ultrasound score × CA-125)	Sensitivity **82.9%**, specificity **87.4**%. ROCkeTS (2024) supports IOTA ADNEX 10% as alternative with higher sensitivity[17]
HE4 (Human Epididymis Protein 4)	Elevation supports malignancy when combined with CA-125 (ROMA score)[18]	Sensitivity **65–83%**, specificity **78–99**% for early epithelial disease[19]

ABBREVIATIONS: CA-125 = Cancer Antigen 125 | RMI = Risk of Malignancy Index | ROMA = Risk of Ovarian Malignancy Algorithm | IOTA = International Ovarian Tumor Analysis | ADNEX = Assessment of Different NEoplasias in the adneXa | HE4 = Human Epididymis Protein 4

CLINICAL PEARL — CLUES TO DIG DEEPER

New-onset 'IBS' in a woman >50 is not IBS until ovarian cancer is excluded. The combination of persistent bloating + early satiety + pelvic discomfort, occurring >12 times per month for less than a year, has higher predictive value than any single symptom. CA-125 + pelvic ultrasound is the appropriate first step before referring to gastroenterology.

Common Oversights

OVERSIGHT/SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD
Attributing persistent GI symptoms in a woman >50 to IBS or constipation	Ovarian cancer commonly presents with **GI-predominant symptoms**. Persistent (>12×/month, <12 months) bloating, early satiety, or pelvic pain in this age group warrants CA-125 + pelvic ultrasound before empiric IBS treatment
Reassuring on the basis of a normal CA-125 in a symptomatic patient	**CA-125 sensitivity is only ~50% in early-stage disease**. **A normal CA-125** with persistent symptoms still **warrants imaging**; consider **HE4/ROMA** or referral if symptoms persist
Ordering CA-125 as a screening test in average-risk asymptomatic women	USPSTF Grade D[20] — Medicare **does not cover screening CA-125**. Order CA-125 only when paired with a documented diagnostic indication (symptoms, mass, or family history)
Dismissing a small amount of new pelvic free fluid in a postmenopausal woman	Any **new postmenopausal pelvic free fluid** warrants further evaluation; it can be the earliest sign of peritoneal involvement before ascites are clinically apparent

ABBREVIATIONS: IBS = Irritable Bowel Syndrome | CA-125 = Cancer Antigen 125 | HE4 = Human Epididymis Protein 4 | ROMA = Risk of Ovarian Malignancy Algorithm | USPSTF = U.S. Preventive Services Task Force | GI = Gastrointestinal

Key Differentials in Elderly

PRESENTATION	DIFFERENTIAL	KEY TESTS
Persistent bloating + early satiety, woman >50[11]	Ovarian cancer **vs.** diverticular disease; gastric malignancy; functional dyspepsia	CA-125, pelvic ultrasound, basic metabolic, CBC; consider abdominal CT, EGD if upper-GI symptoms predominate[17]
New ascites in postmenopausal woman	Ovarian cancer (peritoneal carcinomatosis) **vs.**cirrhotic ascites; CHF; tuberculous peritonitis (rare)[1]	Diagnostic paracentesis with cytology, SAAG, ADA, total protein; CA-125; abdominal/pelvic CT; gynecologic oncology referral
Adnexal mass on imaging in postmenopausal woman	Ovarian cancer **vs.** benign cystadenoma; fibroma; metastasis to ovary (Krukenberg from GI primary)	CA-125, RMI/IOTA ADNEX, contrast-enhanced pelvic MRI, gynecologic oncology referral if complex features or RMI ≥250[7]
Unexplained weight loss + abdominal distension	Ovarian cancer **vs.** pancreatic malignancy; lymphoma; cirrhosis with ascites	**Cross-sectional imaging** (CT abdomen/pelvis), CA-125, CA 19-9, LDH, hepatic panel; targeted biopsy as indicated[6,9]

ABBREVIATIONS: CBC = Complete Blood Count | EGD = Esophagogastroduodenoscopy | CHF = Congestive Heart Failure | SAAG = Serum-Ascites Albumin Gradient | ADA = Adenosine Deaminase | CT = Computed Tomography | MRI = Magnetic Resonance Imaging | LDH = Lactate Dehydrogenase | RMI = Risk of Malignancy Index | IOTA = International Ovarian Tumor Analysis

Comorbidity Screening

CONDITION	PREVALENCE IN THIS POPULATION	SCREENING APPROACH
Hypertension	Highly prevalent in patients ≥65; bevacizumab causes grade ≥3 HTN in 18–23%[21]	**Baseline BP** and at **every visit during bevacizumab**; titrate antihypertensives proactively. CBP HEDIS measure applies
Diabetes mellitus	Significantly more common in elderly ovarian cancer patients (p=0.001)	**Glycemic optimization** before cytoreductive surgery; **HbA1c at baseline** and **every 3–6 months**[22]
Frailty (≥45% of elderly gynecologic cancer patients)[11]	Affects treatment tolerance more than chronological age	Screen with **CARG calculator** or Geriatric Vulnerability Score (**GVS**) before chemotherapy initiation[23]

CONDITION	PREVALENCE IN THIS POPULATION	SCREENING APPROACH
Polypharmacy	≥4 comedications in 68% of elderly ovarian cancer patients;[23] ≥6/day independently worsens OS	**Deprescribing review before** chemotherapy initiation; particular attention to **anticholinergics, sedatives, and CYP3A4 interactors**

ABBREVIATIONS: BP = Blood Pressure | HTN = Hypertension | CBP = Controlling High Blood Pressure (HEDIS) | HEDIS = Healthcare Effectiveness Data and Information Set | CARG = Cancer and Aging Research Group | GVS = Geriatric Vulnerability Score | OS = Overall Survival | CYP3A4 = Cytochrome P450 3A4 | HbA1c = Glycated Hemoglobin

Staging/Severity Matrix

STAGE	THRESHOLD/ RANGE	CATEGORY	ACTION REQUIRED
Stage I	Cancer confined to one or both ovaries/ fallopian tubes	Localized	**Surgical staging**; consider adjuvant chemotherapy by sub-stage and grade. 5-year survival **~93%**[24]
Stage II	Pelvic extension or primary peritoneal cancer below pelvic brim	Regional	**Surgical staging plus platinum-based chemotherapy.** 5-year survival **~74%**[24]
Stage III	Spread beyond pelvis to peritoneum, retroperitoneal lymph nodes, or surface liver/spleen	Distant — peritoneal	**Cytoreductive surgery + platinum-based chemotherapy** ± bevacizumab; PARP-i or bevacizumab maintenance. 5-year survival **~41%**[24,25]
Stage IV	Parenchymal liver/ spleen metastasis (IVA: pleural fluid +cytology) (IVB: parenchymal/ distant)	Distant — visceral	**Neoadjuvant chemotherapy** → interval debulking; maintenance therapy; multidisciplinary palliative integration. 5-year survival **~31%**[24,26]

ABBREVIATIONS: PARP-i = Poly(ADP-ribose) Polymerase inhibitor | FIGO = International Federation of Gynecology and Obstetrics | AJCC = American Joint Committee on Cancer

⚠ RED FLAG — URGENT ACTION

Acute abdomen, suspected ovarian torsion or tumor rupture, bowel obstruction, tense ascites with respiratory compromise, or febrile neutropenia (T ≥38.3°C with ANC <500/µL) during chemotherapy → immediate ED transfer or oncologic emergency response

⚠ RED FLAG — RAPID DECLINE

New palpable adnexal mass in postmenopausal women, rapidly accumulating ascites with elevated CA-125, or rising CA-125 in a patient with prior treated ovarian cancer → same- or next-day gynecologic oncology contact. Postmenopausal palpable ovary is abnormal until proven otherwise

AAVBC PERSPECTIVE

*Ovarian cancer is known as the **silent killer** because symptoms are vague and frequently **mistaken for less serious conditions** until the disease is advanced. Failure in ovarian cancer management is commonly due to a **failure of timing**. By the time most patients receive a diagnosis, the window for curative intervention has already narrowed dramatically. For the primary care clinician, the **key reframe** is that ovarian cancer is a disease with a **gastrointestinal presentation, not exclusively a gynecological one.***
*New-onset bloating, early satiety, pelvic pressure, and urinary urgency occurring more than 12 times per month in a woman over 50 should call for a CA-125 blood test and pelvic ultrasound. However, normal CA-125 and physical exams do not exclude malignancy. **When symptoms are persistent and new-onset in women over 50, imaging and laboratory workup are warranted regardless of exam findings.** AAVBC encourages clinicians to be aware of the heterogeneity of this disease, and to **provide the right treatments for the right patients and the right times**.*

3 MEAT DOCUMENTATION ESSENTIALS

Ovarian cancer documentation must reflect the patient's full clinical complexity: primary site with laterality, every metastatic site individually, and associated conditions (ascites, malnutrition, BRCA status). Each element is a clinical fact that affects care planning and accurately represents disease burden.

Case vignette: A 71-year-old woman with hypertension and known BRCA1 mutation presents for follow-up after cytoreductive surgery and 6 cycles of carboplatin/paclitaxel for FIGO Stage IIIC high-grade serous ovarian cancer (right ovary primary, peritoneal carcinomatosis, omental disease at diagnosis). She is currently receiving olaparib maintenance with stable CA-125 and is co-managed with PCP for hypertension and post-treatment surveillance.

MONITOR: **BP 138/82** today (home log: **134–142/78–86** over past 4 weeks); **CA-125 12 U/mL** (stable since last visit 3 months ago); **weight 64.2 kg** (down 1.1 kg from prior visit, **albumin 3.4 g/dL**).

EVALUATE: Gynecologic oncology surveillance imaging (most recent CT abdomen/pelvis): **no measurable disease**. **Olaparib tolerated mild** grade 1 fatigue and intermittent nausea controlled with ondansetron. **Geriatric Vulnerability Score 1** (albumin component); **PHQ-2 negative**.

ASSESS: Active **high-grade serous ovarian carcinoma**, right ovary (**C56.1**), with prior peritoneal (**C78.6**) and omental (**C78.89**) involvement now in **radiographic remission** on PARP-inhibitor maintenance. **BRCA1 germline mutation** (**Z15.02**). Hypertension (**I10**), controlled on lisinopril. Mild hypoalbuminemia warranting nutritional review.

TREAT: **Continue olaparib** per oncology protocol. **Lisinopril 10 mg daily** continued; **BP target <140/90**. **Nutrition referral** for albumin support. CA-125 and surveillance imaging per gynecologic oncology cadence. Discussed **BRCA cascade testing** options for first-degree relatives. Advanced care planning includes goals of care, treatment preferences in the setting of potential disease progression, and healthcare proxy designation documented in the medical record per patient preference.[27]

Clinical Documentation Elements

- **Link clinical relationships:** Document each metastatic site **separately** (peritoneum, omentum, liver, lung, brain, bone) — one line of 'metastatic ovarian cancer' does not convey clinical complexity and misses HCC 17/HCC 18 distinctions
- **Include current data:** Note the **most recent CA-125 with date, current treatment line and cycle, performance status, and any toxicity grade**. Surveillance documentation depends on dated values, not narrative summaries
- **Specify precisely:** Document **FIGO stage** (with sub-stage where assigned), **histologic subtype** (high-grade serous, endometrioid, clear cell, mucinous, low-grade serous), and **laterality**. **C56.9** should be reserved for genuinely undocumented laterality
- **Document chronicity:** Distinguish **active disease, on-treatment status, and remission**. Use **C56.x** while active; transition to **Z85.43** only when fully in remission and off active therapy per oncology
- **Associated conditions:** Co-document malignant ascites **(R18.0)**, malnutrition **(E43/E44.x)**, BRCA status (**Z15.02** confirmed pathogenic), family history **(Z80.41)**, and any treatment-related toxicities (e.g., hypertension on bevacizumab, cytopenias)[28-31]

Reframing Common Documentation Shortcuts

INSTEAD OF…	DOCUMENT…
'Ovarian cancer' (no laterality, no stage)	High-grade serous carcinoma, right ovary **(C56.1)**, FIGO Stage IIIC at diagnosis (peritoneal carcinomatosis, omental disease) — currently in radiographic remission on olaparib maintenance
'Metastatic ovarian cancer'	Ovarian cancer **(C56.1)** with metastasis to peritoneum **(C78.6)**, omentum **(C78.89)**, and surface liver **(C78.7)**.' Code each site individually
'Patient with ovarian mass'	Once pathology confirms malignancy, retire **D27.x** and document the malignancy code **(C56.x or C48.x)** on the active problem list. Do not leave pre-operative diagnosis codes in place

INSTEAD OF…	DOCUMENT…
'Suspect primary peritoneal cancer — coded as ovarian'	If pathology supports primary peritoneal origin, code **C48.0–C48.8** (HCC 20). Do not default to **C56.x**; the entities are clinically and prognostically distinct

ABBREVIATIONS: FIGO = International Federation of Gynecology and Obstetrics | BRCA = BReast CAncer gene | HCC = Hierarchical Condition Category

DOCUMENTATION IS COMPREHENSIVE CODING

Each ICD-10 code reflects a clinically meaningful element of the patient's disease — laterality, site of metastasis, associated complications, and genetic susceptibility. Capturing these accurately is how the chart represents the patient as they truly are.

4 TREATMENT AND REFERRAL QUICK GUIDE

Ovarian cancer treatment is specialist-led; the PCP role centers on early detection, co-management of comorbidities during active treatment, and coordinated supportive care. Frailty-informed assessment matters more than chronological age in determining treatment intensity.

Therapy Escalation Criteria

TRIGGER*	ACTION
Persistent GI symptoms in woman >50 (>12×/month, <12 months) or new postmenopausal palpable adnexal mass	**Order CA-125 and pelvic ultrasound**; refer to gynecologic oncology if mass is complex, **RMI ≥250, or symptoms persist with negative CA-125**[32]
Imaging or pathology confirming ovarian malignancy	**Cytoreductive surgery** with comprehensive staging (gynecologic oncologist) followed by **platinum-based chemotherapy** per stage and patient fitness[33]
Frail elderly patient (CARG high-risk or GVS ≥3)[34] at diagnosis	Consider **neoadjuvant chemotherapy** with **interval debulking**; dose-adjusted regimens (weekly carboplatin/paclitaxel) per MITO-7/GINECO data
BRCA-mutated or HRD-positive after first-line response	**PARP-inhibitor** maintenance (olaparib BRCA-mutated; olaparib + bevacizumab HRD-positive; niraparib all-comers per PRIMA)[35]

TRIGGER*	ACTION

ABBREVIATIONS: GI = Gastrointestinal | CARG = Cancer and Aging Research Group | GVS = Geriatric Vulnerability Score | HRD = Homologous Recombination Deficiency | PARP = Poly(ADP-ribose) Polymerase | MITO = Multicenter Italian Trials in Ovarian cancer ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Aligned Recommendations

CATEGORY	RECOMMENDED AGENT/ APPROACH*	NOTES
First-line systemic therapy (Stage III–IV)	Carboplatin (AUC 5–6) + paclitaxel (175 mg/m^2) IV q21d × 6 cycles ± bevacizumab[36]	Bevacizumab adds **2–4 months PFS**[37] (GOG-218, ICON7).[38] **Bevacizumab biosimilars** (mvasi, zirabev, alymsys, vegzelma, avzivi, jobevne) are FDA-approved with comparable safety to reference per Cochrane 2024[39]
Maintenance — BRCA-mutated	Olaparib monotherapy	**7-year OS 67% vs 47% placebo**[40] (SOLO-1). Watch for cytopenias and rare MDS/AML signal with prolonged use
Maintenance — HRD-positive (BRCA-wt)	Olaparib + bevacizumab	Median **OS 75 vs 57 months**[41] (PAOLA-1)
Maintenance — all-comers	Niraparib	**PFS improvement** regardless of BRCA/ HRD status[42] (PRIMA)

ABBREVIATIONS: AUC = Area Under the Curve | PFS = Progression-Free Survival | OS = Overall Survival | HRD = Homologous Recombination Deficiency | BRCA-wt = BRCA wildtype | MDS = Myelodysplastic Syndrome | AML = Acute Myeloid Leukemia | FRα = Folate Receptor alpha | NCCN = National Comprehensive Cancer Network ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Non-Pharmacologic Treatment and Lifestyle Modification

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Nutritional support	Albumin ≥3.5 g/dL pre-operatively when feasible	**Sarcopenia and hypoalbuminemia** independently **worsen** surgical and chemo outcomes; refer to dietitian during active treatment[43]
Comprehensive Geriatric Assessment (CGA)	Pre-treatment for any patient ≥70 or with frailty signals	Identifies vulnerability beyond ECOG; supports treatment-intensity decisions

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Exercise/ prehabilitation	Structured pre-operative program when surgery is planned	Reduces **post-operative complications** and improves chemotherapy tolerance in elderly cohorts
Genetic counseling and cascade testing	All patients with ovarian cancer should be offered germline testing per NCCN[13]	Informs **PARP-inhibitor eligibility and family risk**; counseling code 96040 covered

ABBREVIATIONS: CGA = Comprehensive Geriatric Assessment | ECOG = Eastern Cooperative Oncology Group | NCCN = National Comprehensive Cancer Network | PARP = Poly(ADP-ribose) Polymerase

Medication Safety and Dose Adjustments

DRUG/CLASS*	INTERACTION/CONTRAINDICATION	CLINICAL ACTION
Bevacizumab/ biosimilars (mvasi, zirabev, alymsys, vegzelma, avzivi, jobevne)	Hypertension grade ≥3 in 18–23%; ATE 8% in patients ≥65[21] (vs 3% with chemo alone, AURELIA)	**BP** at every visit; **titrate antihypertensives** proactively. Hold **≥28 days** before elective surgery. Monitor for **ATE** symptoms (stroke, MI, TIA) — particularly with diabetes or prior ATE
Olaparib (PARP-i)	Cytopenias; rare MDS/AML signal with prolonged maintenance (Peto OR 2.63)[44]	**CBC monthly**; investigate sustained **cytopenias**. Strong **CYP3A4 inhibitors increase olaparib** exposure — coordinate with oncology
Carboplatin	Renally cleared — dosed by Calvert formula (AUC × [GFR + 25])[45]	Calculate **creatinine** clearance before each cycle; **avoid serum creatinine alone in elderly** with low muscle mass
Liposomal doxorubicin	Cumulative cardiotoxicity; palmar-plantar erythrodysesthesia	**Baseline ECHO/MUGA** in patients with cardiac risk; cumulative dose tracking

ABBREVIATIONS: ATE = Arterial Thromboembolic Event | BP = Blood Pressure | MI = Myocardial Infarction | TIA = Transient Ischemic Attack | PARP-i = Poly(ADP-ribose) Polymerase inhibitor | MDS = Myelodysplastic Syndrome | AML = Acute Myeloid Leukemia | CYP3A4 = Cytochrome P450 3A4 | CBC = Complete Blood Count | AUC = Area Under the Curve | GFR = Glomerular Filtration Rate | ECHO = Echocardiogram | MUGA = Multi-Gated Acquisition scan ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

When to Refer

CRITERION	SPECIALIST	URGENCY
Postmenopausal palpable ovary OR complex adnexal mass on imaging	Gynecologic oncology	Urgent — same- or next-day contact[5]
Persistent GI symptoms (>12×/month, <12 months) in women >50 with elevated CA-125	Gynecologic oncology	Urgent[17]
Newly identified BRCA1/2 pathogenic variant in unaffected woman	Genetic counseling; gynecologic oncology for risk-reducing surgery discussion	Routine — within 4 weeks[13]
Suspected chemotherapy toxicity (grade ≥3 hematologic, GI perforation, sustained HTN)	Treating oncology team	Emergent for GI perforation/febrile neutropenia[44]

ABBREVIATIONS: GI = Gastrointestinal | CA-125 = Cancer Antigen 125 | BRCA = BReast CAncer gene | HTN = Hypertension

Follow-Up Timing

STAGE/CATEGORY	FREQUENCY	LABS TO MONITOR
On active treatment	Per oncology protocol (typically every 3 weeks)	**CBC**, comprehensive metabolic, BP; **CA-125 with each cycle**; toxicity assessment
Maintenance therapy (PARP-i/bevacizumab)	Every 4–8 weeks per agent	**CBC monthly on PARP-i**; BP and urinalysis on bevacizumab; **CA-125 every 1–3 months**
Surveillance (in remission, off therapy)	Every 3 months × 2 years; every 6 months × years 3–5; annually thereafter	**CA-125 each visit**; imaging if symptoms or CA-125 rises; annual **MEAT-documented dx** for chronic problem list
Long-term survivor	Annual	**Cardiovascular** risk reassessment; **bone health** if surgical menopause; survivorship goals-of-care

ABBREVIATIONS: PARP-i = Poly(ADP-ribose) Polymerase inhibitor | CBC = Complete Blood Count | BP = Blood Pressure | CA-125 = Cancer Antigen 125 | MEAT = Monitor, Evaluate, Assess/Address, Treat

Comorbidity Management

COMORBIDITY	APPROACH	CAUTION*
Hypertension on bevacizumab	Pre-treatment BP target <140/90; treat existing HTN to goal before initiation; monthly BP check during therapy	Bevacizumab grade ≥3 HTN 18–23%.[21] **Hold for sustained grade ≥4 HTN** per oncology
Diabetes during chemotherapy	HbA1c every 3 months; coordinate dexamethasone-induced hyperglycemia management	Steroid-induced **glucose elevations** during chemo cycles; communicate with oncology team
Frailty/sarcopenia	Nutrition referral; resistance exercise where tolerated; CARG/GVS scoring before each treatment line	**GVS ≥3 indicates significantly worse OS**, treatment completion, and toxicity
VTE risk	Address prolonged immobility post-surgery; assess for DVT/PE on rapid clinical change	Ovarian cancer + chemotherapy is a **high-VTE setting**; bevacizumab adds modest incremental risk

ABBREVIATIONS: BP = Blood Pressure | HTN = Hypertension | HbA1c = Glycated Hemoglobin | CARG = Cancer and Aging Research Group | GVS = Geriatric Vulnerability Score | OS = Overall Survival | VTE = Venous Thromboembolism | DVT = Deep Vein Thrombosis | PE = Pulmonary Embolism ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Cost-Smart Options

BRAND (EST. COST)*	GENERIC/ALTERNATIVE (EST. COST)*	EST. MONTHLY SAVINGS	COST-SMART TIP
Avastin (reference bevacizumab)	Mvasi, zirabev, alymsys, vegzelma, avzivi, or jobevne (FDA-approved biosimilars)	~$1,193 per OCM episode (avg)[46]	Cochrane 2024 (23 RCTs, 10,619 participants)[39] confirms equivalent serious **AE profile**. Discuss **substitution** with oncology when initiating maintenance
Olaparib (Lynparza)	No therapeutic substitute; PARP-i class differs by toxicity	—	**Patient-assistance programs** and **Medicare Part D** LIS can reduce out-of-pocket; coordinate with oncology pharmacy

BRAND (EST. COST)*	GENERIC/ALTERNATIVE (EST. COST)*	EST. MONTHLY SAVINGS	COST-SMART TIP
Liposomal doxorubicin (Doxil)	Pegylated liposomal doxorubicin (Caelyx) — generic available	Variable — formulary-dependent	Confirm formulary placement; **generic switch** typically straightforward

ABBREVIATIONS: OCM = Oncology Care Model | PARP-i = Poly(ADP-ribose) Polymerase inhibitor | LIS = Low-Income Subsidy | AE = Adverse Event ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Patient Education and Adherence

AAVBC PERSPECTIVE

*From the AAVBC's perspective, **patient education in ovarian cancer must begin before a diagnosis is confirmed**. Women over 50, particularly those with BRCA mutations, Lynch syndrome, or a significant family history, should be counseled on symptom persistence as a clinical threshold, risk-reduction options, and the importance of cascade testing for first-degree relatives. Once diagnosed, shared decision-making should address treatment sequencing, PARP inhibitor maintenance implications, and quality-of-life considerations across the care continuum, including nutritional support and functional status during treatment. Documentation should reflect this complexity: BRCA status documented with the appropriate Z-code, metastatic sites coded individually, performance status noted, and treatment-related toxicities recorded with their ICD-10 correlates. A clinically complete record is not an administrative burden, it is the evidence that the right care was delivered to the right patient at the right time.*

DOCUMENTATION — PATIENT EDUCATION

Document specific elements: 'Reviewed treatment plan and expected toxicities with patient; discussed CA-125 surveillance cadence; advised on when to call (fever ≥38.3°C, sustained BP elevation, new neurologic symptoms). Reviewed BRCA cascade testing options for first-degree relatives.' Patient education supports MEAT 'Assess' and 'Treat' elements when documented with specifics.

Quality Metrics Tie-In

MEASURE	MEASURE'S STANDARD	APPLICABILITY TO OVARIAN CANCER
Controlling High Blood Pressure (CBP) MIPS #236/NQF 0018	**Denominator:** patients 18-85 with hypertension (≥2 outpatient visits with HTN diagnosis in MP or year prior) **Numerator:** most recent BP <140/90 mmHg during MP **Exclusions:** ESRD, hospice, palliative care, pregnancy[47]	**Directly applicable for patients on bevacizumab maintenance therapy**; grade 3/4 hypertension can occur in patients receiving bevacizumab-containing regimens for ovarian cancer, making this one of the most common dose-limiting toxicities to monitor
Breast Cancer Screening (BCS) MIPS #112/NQF 2372/Stars C01	**Denominator:** women 41-74 with a qualifying visit during MP (MIPS #112 denominator begins at 41, not 50 as in some prior HEDIS specifications) **Numerator:** mammography (any modality) performed within 27 months prior to the end of MP **Excl:** bilateral mastectomy, long-term care residence ≥66 with limited life expectancy, hospice, palliative care[48]	**Documents BRCA carrier overlap**; BRCA1 carriers face up to 44% cumulative ovarian cancer risk and 72% cumulative breast cancer risk by age 80, while BRCA2 carriers face up to 17% ovarian and 69% breast cancer risk over the same period — ovarian cancer patients with a BRCA mutation remain at substantially elevated breast cancer risk and should not be excluded from screening surveillance[49]
Medication Reconciliation Post-Discharge (MRP) MIPS #46/NQF 0097	**Denominator:** patients ≥18 seen in outpatient setting within 30 days of inpatient discharge **Numerator:** discharge medication list reconciled with current medication list documented in outpatient record **Exclusions:** none specified	**Critical for complex oncology patients during care transitions, particularly after debulking surgery or hospitalization for chemotherapy toxicity**; represents a structured deprescribing review opportunity for medications no longer indicated post-discharge[50]

ABBREVIATIONS: CBP = Controlling High Blood Pressure | NQF = National Quality Forum | BCS = Breast Cancer Screening | MRP = Medication Reconciliation Post-Discharge | HEDIS = Healthcare Effectiveness Data and Information Set | HTN = Hypertension

QUALITY OUTCOME

There is no direct HEDIS or CMS Star Rating measure for ovarian cancer screening, diagnosis, or treatment — reflecting USPSTF Grade D against routine screening. Indirect measures (CBP, BCS, MRP) document care-quality elements that matter for this population.

DOCUMENTATION

Treatment intensity decisions (full-dose combination vs. dose-modified vs. single-agent) must be supported by frailty documentation: ECOG, CARG score components, GVS components (ADL, IADL, HADS, albumin, lymphocyte count). Document the basis for treatment intensity — it explains the clinical record and supports oncology continuity.

5 CODING REMINDERS AND CASE EXAMPLES

Documentation Specificity

- **Stage/Severity:** Document **FIGO stage** and **sub-stage** (e.g., IIIC, IVA) and **histologic subtype** (high-grade serous, endometrioid, clear cell, mucinous, low-grade serous). Sub-stage and grade affect treatment selection and prognosis[51]
- **Etiology: BRCA1/BRCA2** status, **Lynch syndrome** status, or other germline pathogenic variants — document as **Z15.02** (BRCA1/2 ovarian susceptibility) when confirmed; supports **PARP-inhibitor eligibility and cascade testing**[52]
- **Current status:** Most recent **CA-125** with date, current treatment line and cycle (or remission status with last imaging date), and active toxicities. Surveillance documentation is anchored by dated values, not narrative summaries[53]
- **Associated conditions: Malignant ascites (R18.0)**, **malnutrition (E43, E44.x)**, **hypoalbuminemia**, treatment-related **cytopenias**, **hypertension** on bevacizumab, and BRCA family-history status **(Z80.41)** — each is clinically meaningful and may carry independent HCC or HEDIS implications
- **Chronicity:** Distinguish active disease (use **C56.x** with relevant metastatic codes) from remission status (**Z85.43** — personal history of malignant neoplasm of ovary) once active treatment ends and oncology confirms remission

Annual Clinical Review and Confirmation

- **Annual review:** An active ovarian cancer diagnosis must be reassessed annually with **face-to-face or synchronous audio-video** visit and MEAT documented by 12/31. Use **C56.x** while active disease persists; transition to **Z85.43** only with documented remission and oncology confirmation
- **Visit modality:** In-person or video telehealth qualifies when meaningful evaluation occurs — clinical review of treatment status, CA-125 trend, toxicity burden, and goals-of-care
- **Clinical context:** Under HCC V28, primary ovarian **(C56.1–C56.3)** maps to HCC 22 (RAF 0.363); primary peritoneal **(C48.x)** maps to HCC 20 (RAF 1.136); metastatic sites map to HCC 17 (RAF 4.209) or HCC 18 (RAF 2.341) depending on site. **Accurate site-by-site documentation reflects true clinical burden**
- **Avoid rollover:** Do not copy forward prior year's notes. Update treatment line, cycle, CA-125 with date, current toxicities, performance status, and any new metastatic sites or remission events

Good Documentation is Comprehensive Coding

EHR SHORTCUT/RISK	PREFERRED DOCUMENTATION LANGUAGE
Carrying forward 'C56.9 — unspecified ovary' after pathology report	Once pathology or imaging confirms laterality, retire **C56.9** and document the **laterality-specific code (C56.1, C56.2, or C56.3)**. **Do not allow unspecified codes** to persist on the active problem list
Listing 'metastatic ovarian cancer' without site-specific codes	Document **each metastatic site individually**: peritoneum **(C78.6)**, liver **(C78.7)**, lung **(C78.0x)**, omentum/intestine **(C78.89)**, brain **(C79.31)**, bone **(C79.51)**. HCC 17 vs. HCC 18 assignment depends on the specific site
Coding primary peritoneal cancer as C56.x	**Primary peritoneal cancer is a distinct entity**. Code **C48.0–C48.8** with pathology supporting primary peritoneal origin; this maps to HCC 20, not HCC 22
Leaving D27.x ('benign neoplasm of ovary') in the chart after malignancy is confirmed	Update to **C56.x** once final pathology returns; the pre-operative diagnosis should not persist in the chronic problem list
Omitting BRCA status when known	Document **Z15.02** for confirmed **BRCA1/2 pathogenic variant**; supports cascade testing referral and PARP-inhibitor eligibility documentation

ABBREVIATIONS: HCC = Hierarchical Condition Category | BRCA = BReast CAncer gene | PARP = Poly(ADP-ribose) Polymerase

EHR Workflow Tips

- **[EHR TIP — Smartphrase]** Build a **.OVCA** dot phrase that auto-populates: active high-grade serous ovarian carcinoma, laterality, **FIGO stage**, current treatment regimen and cycle number, most recent **CA-125** value with date, **ECOG** score, treatment tolerance/toxicity, and **BRCA** status (confirmed/pending/negative). Sourced from pathology, lab, and oncology notes. Eliminates free-text inconsistency and supports MEAT documentation in a single paste
- **[EHR TIP — Alert]** Worklist filter "Ovarian Cancer Active, No Annual Visit" = surfaces patients with **C56.1**, **C56.2**, **C56.9** (or **C48.x** for peritoneal primary), or **Z85.43** (personal history) on the active problem list without a MEAT-documented encounter in the current calendar year through Q3. Surfaces patients for outreach ahead of the year-end re-documentation deadline, before annual diagnosis confirmation lapses
- **[EHR TIP — Best Practice]** Problem list hygiene: maintain the laterality-specific active code (**C56.1** right ovary, **C56.2** left ovary, or **C56.9** unspecified — confirm correct site code, as **C56.3** is not a valid ICD-10-CM code) plus any active metastatic site codes (**C78.6** retroperitoneum/peritoneum, **C78.7** liver/intrahepatic bile duct, **C78.0x** lung, **C78.89**other digestive organs, **C79.31** brain, **C79.51** bone, **C79.60–C79.62** ovary). Retire **D27.x** (benign ovarian neoplasm) once pathology confirms malignancy. Add **Z15.02** for genetic susceptibility to malignant neoplasm (BRCA1/BRCA2) once status is confirmed
- **[EHR TIP — Workflow]** Annual diagnosis confirmation: set a recurring task to re-document the active ovarian cancer code each calendar year before 12/31, refreshed with a current **CA-125** value, treatment status, and updated toxicity profile. Supports continuity of HCC mapping and RAF accuracy through the year-end sweep deadline
- **[EHR TIP — Order Set]** "Adnexal Mass / Suspected Ovarian Cancer" bundle: **CA-125**, **CBC with differential**, **comprehensive metabolic panel**, **transvaginal pelvic ultrasound (76830)**, and a gynecologic oncology referral template — supporting ICD-10 codes auto-populate based on findings
- **[EHR TIP — Referral]** Trigger a gynecologic oncology referral workflow when **CA-125 ≥35 U/mL** combined with a complex adnexal mass or a postmenopausal palpable ovary on exam. Pre-populates clinical context, recent imaging, and lab values into the referral note

Brief Case Examples

✓ SUCCESS — COMPREHENSIVE DOCUMENTATION

SCENARIO | 72-year-old woman with hypertension and family history of breast cancer (sister, age 58); presents to PCP for new bloating, early satiety, and pelvic discomfort over the past 3 months (occurring most days).

PATIENT | Postmenopausal, BMI 29, BP controlled on lisinopril 10 mg.

DOCUMENTATION | PCP documented: 'Persistent bloating, early satiety, and pelvic pressure occurring >12×/month for 3 months in a 72-year-old postmenopausal woman with significant family history of breast cancer (sister at 58). Ordered CA-125 and transvaginal pelvic ultrasound (R10.13 abdominal pain, R19.0 abdominal swelling, Z80.3 family history of breast cancer). 57 calculation pending imaging.' CA-125 returned at 184 U/mL; ultrasound showed a complex 6 cm adnexal mass with septations. Same-day gynecologic oncology referral placed. Pathology: high-grade serous ovarian carcinoma, right ovary; staging surgery confirmed FIGO Stage IIIC.

OUTCOME | Diagnosis at potentially earlier stage IIIC vs. IV with peritoneal and omental disease only; eligible for first-line cytoreductive surgery and platinum-based chemotherapy; BRCA1 germline mutation identified, supporting olaparib maintenance eligibility. Coding documented C56.1, C78.6, C78.89, Z15.02, I10 — comprehensive representation of clinical complexity.

⚠ PITFALL — INSUFFICIENT DOCUMENTATION

DOCUMENTATION AS WRITTEN | '72 yo F with bloating and abdominal discomfort. Likely IBS. Trial of dietary modification and follow-up in 3 months.' No CA-125 or imaging ordered.

CONSEQUENCE | Symptoms persist; patient returns 6 months later with worsening ascites, weight loss, and new dyspnea. Imaging shows extensive peritoneal carcinomatosis, surface liver disease, and bilateral pleural effusions. Final diagnosis: FIGO Stage IVA high-grade serous ovarian carcinoma; ascites limits surgical candidacy, requiring neoadjuvant chemotherapy.

RAF IMPACT | Original encounter coded only with R14.0 (abdominal distension) and K58.9 (IBS unspecified) — neither maps to an HCC. After diagnosis, the chart must document C56.1 (HCC 22, RAF 0.363), C78.6 (HCC 17, RAF 4.209), C78.7 (HCC 17), and J90 (pleural effusion). Earlier intervention would have meant earlier-stage disease and a meaningfully different clinical trajectory.

FIX | In a postmenopausal woman with persistent (>12×/month, <12-month) bloating, early satiety, or pelvic pressure, order CA-125 and pelvic ultrasound BEFORE attributing symptoms to IBS. Document supporting ICD-10 (R10.x, R19.0, N94.x) to support diagnostic — not screening — coverage.

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