



Welcome! We will get started shortly.

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REIMagine YOU CAN FEEL ANOTHER WAY



Cancer in Primary Care

Presented by Bright HealthCare



Our mission:
Making healthcare right. Together.





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Making healthcare right. Together.



What does this mean?





Our vision:



Collaborating with Care Partners to make healthcare simpler, personal, and more affordable.





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Correlation between Coding & Cancer Care Resources

Cost of cancer care varies, depending on many factors.



For example, an otherwise healthy patient with low-grade prostate cancer is not going to need as many resources as a patient with metastatic prostate cancer & multiple ancillary conditions.

A patient who is in remission for 5 years from breast cancer is not going to need as many resources as someone who is currently undergoing treatment for breast cancer.

Allocation of resources is greatly impacted by coding & documentation.



Does the documentation truly reflect how sick the patient is?
Are the most specific, accurate, and thorough codes being reported?

Cancer in Primary Care

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Today's Agenda



Impact to Patient Risk Scores



Clinical Insights & Best Practices



Documentation Discussion



Cancer Documentation & Coding Resources



Impact to Patient Risk Scores

V24 Cancer HCC Categories & Associated RAF

HCC	Description	RAF
8	Metastatic Cancer & Acute Leukemia	2.659
9	Lung & Other Severe Cancers	1.024
10	Lymphoma & Other Cancers	0.675
11	Colorectal, Bladder, & Other Cancers	0.307
12	Breast, Prostate, & Other Cancers & Tumors	0.150



Disease Interaction Score:
Immune Disorders (HCC 47) + Cancer (HCCs 8-12) = 0.838

Numbers are based on the V24 Medicare HCC model. For Medicare V28 HCC model details, please refer to: [Announcement of Calendar Year \(CY\) 2024 Medicare Advantage \(MA\) Capitation Rates and Part C and Part D Payment Policies \(cms.gov\)](#)

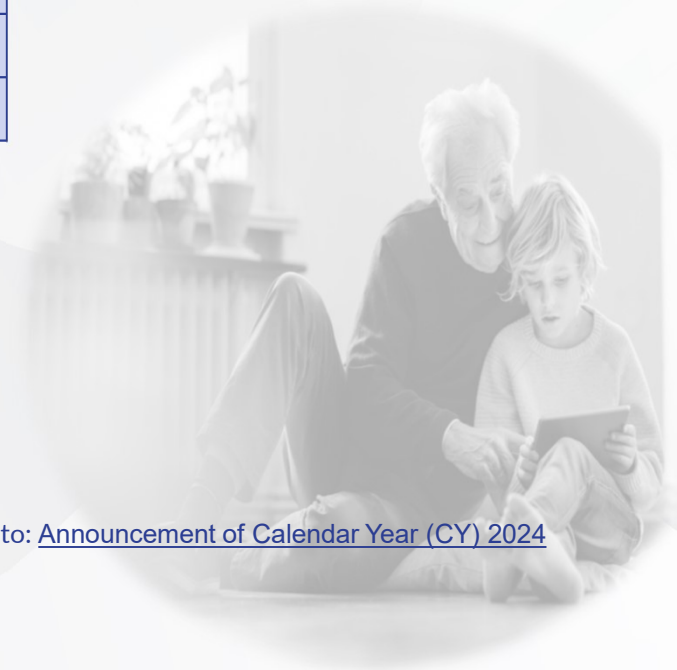
V28 Cancer HCC Categories & Associated RAF

HCC	Description	RAF
17	Cancer Metastatic to Lung, Liver, Brain...	4.209
18	Cancer Metastatic to Bone...	2.341
19	Myelodysplastic Syndromes, Multiple Myeloma...	1.798
20	Lung & Other Severe Cancers	1.136
21	Lymphoma & Other Cancers	0.671
22	Bladder, Colorectal, & Other Cancers	0.363
23	Prostate, Breast, & Other Cancers & Tumors	0.186

Cancers Prevalent in Aging Populations

Condition	ICD-10	RAF
Prostate Cancer	C61	0.150
Breast Cancer	C50.--	0.150
Malignant Melanomas	C43.--	0.150
Chronic Lymphocytic Leukemia	C91.1-	0.675
Secondary Cancer	C---.--	2.659

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Cancer Complications & Ancillary Conditions

Condition	ICD-10	RAF
Chronic Kidney Disease, 3-4	N18.--	0.069
Chronic Kidney Disease, 5	N18.5	0.289
End-Stage Renal Disease (ESRD)	N18.6	0.289
Acute Renal Failure	N17.9	0.435
Protein-Calorie Malnutrition	E46	0.455
Cachexia	R64	0.455
Artificial Openings (Trach)	Z93.0	1.000
Artificial Openings (Other)	Z93.-	0.534
Chronic Respiratory Failure	J96.10	0.282
Acute Respiratory Failure	J96.00	0.282
Pulmonary Fibrosis	J84.10	0.219
Hemiparesis due to CVA	I69.---	0.437

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Cancer Complications & Ancillary Conditions

Condition	ICD-10	RAF
Seizure Disorder	G40.909	0.220
Acute DVT	I82.40-	0.288
Chronic DVT	I82.50-	0.288
Major Depression, Recurrent	F33.9	0.309
Substance Abuse & Dependence	F1-.-	0.329
Senile Purpura	D69.2	0.192
Immune Thrombocytopenia	D69.3	0.192
Thrombocytopenia	D69.6	0.192
Myelodysplastic Syndrome	D46.9	1.372
Immunodeficiency due to Chemo	D84.821	0.665
Polyneuropathy due to Chemo	G62.0	0.472

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Clinical Insights & Best Practices

To See our Dear Enrolled Lives Comprehensively, Holistically



Comprehensive History



Medication Reconciliation, with a Diagnosis attached to Every Medication



Vitals: Did you include Pain? Height? Weight? BMI? % Meals? Last Bowel Movement?



Physical Exam: Did you describe this person? Did you include the skin exam and note any bruising? How about temporal wasting & cachexia? Peripheral edema or lower extremity hair loss?



Labs & X-rays



Every Diagnosis Counts with a Plan of Care



Goals of Care Conversation

Goals of Care



Goals of Care Conversation

After your ICP conversation is complete, say to the member...I have one more question for you...

"Please don't be scared by this question, I must ask everyone this question. Remember, YOU are the captain of your care, and YOU get to decide the care you receive. All of us naturally have our heart stop someday. When your heart naturally stops beating someday, do you want to have a natural death? Or do you want CPR? Hooked up to machines to breathe for you? Hooked up to machines to feed you?"

1 in 3 adults

completes any type of advance directive for end of life care



1 in 4 indicators

in the HEDIS Care for Older Adults (COA) measure, advanced care planning targets members 65 and older



Reminder →

It is not the job of the care managers, UM nurses, DC planners, or social workers to fill out the POLST. However, it is our job to FACILITATE these goals of care conversations.

- Document your conversation in **Advance Care Planning** assessment in panorama which ask the following questions:
 - Have you started planning ahead for your healthcare?
 - Have you completed any advance care planning documents?
 - Who has a copy of your advance care planning documents?
 - If the member does not have any form of advance care planning in place, you will ask if the member is interested in talking about goals of care
 - Inquire if the member needs assistance with completing the document(s). If so, discuss, document, and facilitate talking with their PCP.

Documentation Best Practices

Provider Documentation: Cancer Documentation Tips & Best Practices

Tip: Be sure that documentation clearly specifies "active" cancer versus "history of."

Documentation best practices:

- Document current cancer treatment details, such as:
 - Short- and long-term therapies
 - Adjuvant therapy
 - Surveillance (watchful waiting)
 - Palliative care
 - Patient refuses treatment

*Note that documentation of prophylactic treatment alone does not support an "active" cancer ICD-10 code.

- For metastatic cancer, document both the primary (original) site and the secondary (metastasis) site
- Document any cancer-related complications and ancillary conditions.

Coding callouts:

- When a malignancy has been excised or eradicated and there is no further treatment of the malignancy, a code from category Z85 (personal history of malignancy neoplasm) should be assigned.
- When there is metastatic cancer, list the primary site code(s) first, then the secondary (metastasis) site code(s) second.

Document the diagnosis, status, and plan (**DSP**) in your final assessment. For example:

Diagnosis:	Status:	Plan:
Rectal cancer with metastasis to the inguinal lymph nodes	Newly diagnosed with rectal cancer, initially evaluated on 7/22/22. 8/5 right inguinal node core biopsy showed metastatic carcinoma, per oncologist records.	Continue oncologist's plan of neoadjuvant chemotherapy and radiation to the rectal area and inguinal nodes.

Your note should include **MEAT** (**m**onitor, **e**valuate, **a**ssess, **t**reat) details that specifically address your patient's conditions, as well as a comprehensive plan of care.



Documentation Discussion

Patient One: 74-year-old female

1

74-yo female has **breast cancer**, s/p lumpectomy, chemo and radiation. She is **now on tamoxifen for five years.**

2

74-yo female is on **prophylactic tamoxifen** for five years, **no current evidence of disease**

Patient One: 74-year-old female

Impact to RAF Score

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Patient One: 74-year-old female

Impact to RAF Score

1

74-yo female has **breast cancer**, s/p lumpectomy, chemo and radiation. She is **now on tamoxifen for five years.**

74 yo female

0.386

2

74-yo female is on **prophylactic tamoxifen** for five years, **no current evidence of disease**

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Impact to RAF Score

74 yo female	0.386
C50.919 <i>Breast cancer</i>	0.150

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74 yo female	0.386
C50.919 <i>Breast cancer</i>	0.150
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74 yo female	0.386
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74 yo female	0.386
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0.536

74 yo female	0.386
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Z85.3 <i>H/o breast cancer</i>	0.000
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Patient Two: 68-year-old male

1

68-yo male with **rectal cancer & inguinal lymph node cancer**. Continue to follow-up with oncologist.

2

68-yo male with **rectal cancer**. Biopsy-proven **right inguinal lymph node metastasis**. Neoadjuvant chemotherapy & radiation to the rectal area and inguinal nodes is planned with consideration of resection the primary and inguinal lymph node dissection.

Patient Two: 68-year-old male

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Patient Two: 68-year-old male

Impact to RAF Score

1

68-yo male with **rectal cancer & inguinal lymph node cancer**. Continue to follow-up with oncologist.

68 yo male
C20
Rectal cancer

0.386
0.307

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Patient Two: 68-year-old male

Impact to RAF Score

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68-yo male with **rectal cancer & inguinal lymph node cancer**. Continue to follow-up with oncologist.

68 yo male
C20
Rectal cancer
C85.85
*Inguinal lymph
node cancer*

0.386
0.307

Trumped

2

68-yo male with **rectal cancer**. Biopsy-proven **right inguinal lymph node metastasis**. Neoadjuvant chemotherapy & radiation to the rectal area and inguinal nodes is planned with consideration of resection the primary and inguinal lymph node dissection.

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Impact to RAF Score

68 yo male	0.386
C20	0.307
Rectal cancer	
C85.85	Trumped
Inguinal lymph node cancer	

0.693

Patient Two: 68-year-old male

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Impact to RAF Score

68 yo male	0.386
C20	0.307
Rectal cancer	Trumped
C85.85	
Inguinal lymph node cancer	

0.693

68 yo male	0.386
------------	-------

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Impact to RAF Score

68 yo male	0.386
C20	0.307
Rectal cancer	
C85.85	Trumped
Inguinal lymph node cancer	

0.693

68 yo male	0.386
C77.4	2.659
Secondary inguinal lymph node cancer	

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Impact to RAF Score

68 yo male	0.386
C20	0.307
Rectal cancer	
C85.85	Trumped
Inguinal lymph node cancer	

0.693

68 yo male	0.386
C77.4	2.659
Secondary inguinal lymph node cancer	
C20	Trumped
Rectal cancer	

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Impact to RAF Score

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C20	0.307
Rectal cancer	
C85.85	Trumped
Inguinal lymph node cancer	

0.693

68 yo male	0.386
C77.4	2.659
Secondary inguinal lymph node cancer	
C20	Trumped
Rectal cancer	

3.045

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Cancer Resources

Cancer Documentation & Coding Resources



Medicare HCC V24 Documentation & Coding Quick Guide



Provider Documentation Tip Sheet



Documentation & Coding Guide



Provider Education Biteable Video



All resources are available on the HCC Training Page: [Healthcare Provider Home | Brand New Day HMO \(bndhmo.com\)](#)

HCC Documentation & Coding Reference Guide

If your patient has any of these problems, document the diagnosis, assessment, and plan (DSP), and report the corresponding code at least annually.

Includes documentation & coding tips for over twenty different condition categories!

Examples	ICD-10	CMS	RAF Value	Documentation and Coding Notes
Chronic Lung Disease				
Chronic respiratory failure	J96.10	84	0.282	<ul style="list-style-type: none"> Smoker's cough = mild chronic bronchitis. For patients who are dependent on supplemental oxygen (SpO2 < 87% on RA), consider chronic respiratory failure diagnosis.
Smoker's cough	J41.0	111	0.335	
COPD, unspecified	J44.9	111	0.335	
Chronic obstructive pulmonary disease (COPD), other	J44.X	111	0.335	
Emphysema	J43.X	111	0.335	
Pulmonary fibrosis	J84.10	112	0.219	
Neurologic Disease / Cerebrovascular Accident (CVA)				
Sequelae and late effects of stroke (hemiplegia, hemiparesis)	I69.XXX	103	0.437	<ul style="list-style-type: none"> For sequelae and late effects of stroke, document cause-and-effect relationship of CVA and specific related deficits. Acute CVA (ICD-10 I63.XXX) should only be documented during the initial episode of care. Post-discharge, document "history of CVA" with or without residual or late effects. History of CVA without residual effects (ICD-10 code Z86.73) has no RAF value. For patients with a history of CVA with residual effects, utilize the appropriate ICD-10 code(s) from codeset I69.XXX.
Parkinson's disease	G20	78	0.606	
Multiple sclerosis	G35	77	0.423	
Paralysis	G83.9	104	0.331	
Seizure disorder	G40.909	79	0.220	
Cardiac Disease				
CHF	I50.9	85	0.331	<ul style="list-style-type: none"> Consider: a patient's CHF may be controlled and remain stable with medications or surgical interventions (ACEI's, ARB's, diuretics, BBs, digoxin, ICD's, valve replacements, etc.). Consider: a patient's a-fibb may be controlled and remain in NSR with surgery, procedures, or medications (cardioversion, ablation, BBs, CCBs, antiarrhythmics).
Atrial fibrillation	I48.91	96	0.268	
Coronary artery disease with angina	I25.119	88	0.135	
Angina	I20.9	88	0.135	
Unstable angina	I20.0	87	0.195	
Pulmonary hypertension	I27.20	85	0.331	
Cor pulmonale	I27.81	85	0.331	
Cardiomyopathy	I42.9	85	0.331	
Abdominal aortic aneurysm	I71.4	108	0.288	
Aortic atherosclerosis/calcifications	I70.0	108	0.288	
				<ul style="list-style-type: none"> Often missed on radiologic reports. Must have CXR/US/CT scans verifying, document date of exam.

Provider Documentation: Cancer Documentation Tips & Best Practices

Tip: Be sure that documentation clearly specifies “active” cancer versus “history of.”

Documentation best practices:

- Document current cancer treatment details, such as:
 - o Short- and long-term therapies
 - o Adjuvant therapy
 - o Surveillance (watchful waiting)
 - o Palliative care
 - o Patient refuses treatment

*Note that documentation of prophylactic treatment alone does not support an “active” cancer ICD-10 code.

- For metastatic cancer, document both the primary (original) site and the secondary (metastasis) site
- Document any cancer-related complications and ancillary conditions.

Coding callouts:

- When a malignancy has been excised or eradicated and there is no further treatment of the malignancy, a code from category Z85 (personal history of malignancy neoplasm) should be assigned.
- When there is metastatic cancer, list the primary site code(s) first, then the secondary (metastasis) site code(s) second.

Document the diagnosis, status, and plan (**DSP**) in your final assessment. For example:

Diagnosis:	Status:	Plan:
Rectal cancer with metastasis to the inguinal lymph nodes	Newly diagnosed with rectal cancer, initially evaluated on 7/22/22. 8/5 right inguinal node core biopsy showed metastatic carcinoma, per oncologist records.	Continue oncologist’s plan of neoadjuvant chemotherapy and radiation to the rectal area and inguinal nodes.

Your note should include **MEAT** (monitor, evaluate, assess, treat) details that specifically address your patient’s conditions, as well as a comprehensive plan of care.

Coding and Documentation Guide: Cancer

Accurate coding and documentation are fundamental to the risk adjustment process and crucial to representing each patient's complex health profile. Bright HealthCare's coding and documentation guides equip coders and medical staff with the information needed to support complete and accurate coding and documentation.

Documentation best practices

- Documentation must be provided. Coders cannot assume diagnoses exist based on medication lists or physician orders.
- All conditions that coexist at the time of the encounter, and require or affect patient care, treatment, or management should be documented and coded.
- Coders cannot code current conditions from problem lists, medical history, or superbills.
- Documentation should clearly define cancer status ("active" or "history of").
- Cancer metastasis and cancer-related complications should be clearly documented.
- Coders must verify clinical documentation for all diagnoses using the MEAT tool (monitor, evaluate, assess, treat). One or more MEAT detail is required for each condition requiring or affecting patient care.

Monitor	Evaluate	Assess	Treat
Symptoms Disease progression/ regression Ordering of tests Referencing labs/tests	Test results Medication effectiveness Response to treatment Physical exam findings	Test ordered Counseling Record review Discussion	Medication Therapies Referral Other modalities
MEAT Examples: Cancer			
Prostate cancer — Improved; continue monitoring with PSA.	Malignant neoplasm of lower-inner quadrant of right breast — Biopsy done on 9/4. Results show stage 2 breast cancer.	Malignant neoplasm of pancreas — Discussed palliative care options.	Malignant neoplasm of pancreas — Getting Lupron injections every 6 mo. Follows with urologist.

Case study #2: Incomplete documentation

Gender: F **DOB:** MM/DD/1962

Chief complaint: Thigh pain

History of present illness

59-year-old female here for bilateral thigh tingling and numbness and right groin pain x 1 month. Pt also has cold and redness of bilateral hands w/o joint pain, swelling. Hands worse in winter. She is on aromasin oral chemo x 5 years after breast cancer treatment including bilateral mastectomy.

Physical exam

Constitutional: Appearance – She is well-developed.
Eyes: General – Lids are normal.
Cardiovascular: Rate and rhythm – Normal rate and regular rhythm.
Heart sounds – S1 normal and S2 normal.
Pulmonary: Effort – Pulmonary effort is normal. Breath sounds – Normal breath sounds.
Musculoskeletal: Normal range of motion. Left hip – She exhibits normal range of motion, normal strength, no bony tenderness, no swelling and no deformity. Left groin pain. No swelling, pain with palpation. Valgas/vargas movements w/o pain. Flexion/extension w/o pain. Unable to replicate pain. Pt states pain is "deep" in groin.
Skin: General – Skin is warm and dry.
Neurological: Mental status – She is alert and oriented to person, place, and time. Numbness and tingling bilateral thighs. Clinical exam normal.
Psychiatric: Behavior – Behavior normal.

Assessment & plan

- Left groin pain
2017 to 2019 dexa imaging showing significant decrease in bone density, however still "normal"
Will do x-ray of lumbar and groin
H/o aggressive breast cancer
- Numbness and tingling of both legs
Lumbar and hip x-ray today
Pt is on exemestane x 5 years
- Malignant neoplasm of overlapping sites of right female breast (CMS/HCC)
In remission. Stable x 5 years.
On exemestane per oncology.
F/u with breast specialist and oncology as scheduled.
- History of breast cancer in female
Stable
Currently on exemestane for prophylaxis.
F/u with specialist/oncology as scheduled.

Jane Doe, MD

Documentation supports history of breast cancer in female (Z85.3).

Is breast cancer active or history of?

Documentation includes "in remission," "history of," and "currently on exemestane for prophylaxis."

Coding for cancer

When can cancer be coded as “active”?

Cancer can be coded as “active” when documentation indicates any of the following:

- Patient is currently receiving treatment for cancer (includes “watchful waiting”).
- Patient has been diagnosed with cancer and is not undergoing treatment.

When does active cancer become “history of”?

Cancer should be coded as “history of” when documentation indicates:

- The primary malignancy has been excised or eradicated; and
- No further treatment is directed to the site; and
- There is no evidence of an existing malignancy.

If the treatment is preventive or prophylactic, in most instances, the correct code to report would be a personal “history of” cancer rather than an active code.

Example: Patient has history of breast cancer. Below is the correct coding for this patient:

Z85.3	Personal history of malignant neoplasm of breast
-------	--

Metastatic cancer

Cancer is described as primary or secondary (metastatic). A primary cancer refers to the original site or point of origin of the malignancy. A secondary cancer refers to the site or sites where the malignancy has spread (metastasis). Documentation should clearly describe any metastasis and call out the primary and secondary sites. Both the primary and secondary cancer should be coded.

Example: Patient has primary prostate cancer that has metastasized to the bones. Below is the correct coding for this patient:

C61	Malignant neoplasm of prostate
C79.51	Secondary malignant neoplasm of bone

Cancer complications

Conditions related to cancer and complications of care should be clearly documented and linked to the cancer. For example:

- Anemia due to adenocarcinoma of the colon
- Diabetes mellitus secondary to pancreatic carcinoma
- Pathological fracture resulting from metastatic stage 4 ovarian carcinoma

Clinical indicators

Familiarity with clinical cancer indicators (i.e., testing, treatment, medication, etc.) is helpful in recognizing the potential presence and severity of a condition. **Coders cannot assign diagnosis codes based solely on test results and medication lists**, but these clinical indicators can help highlight opportunities for more complete and accurate documentation.

Common tests used to diagnose cancer

Test	Purpose
Laboratory body fluid and blood tests	These tests help identify abnormalities that can be caused by cancer.
Imaging tests	Imaging tests allow providers to examine a patient’s bones and internal organs in a noninvasive way. Imaging tests used in diagnosing and monitoring cancer may include a computerized tomography (CT) scan, bone scan, magnetic resonance imaging (MRI), positron emission tomography (PET) scan, ultrasound, and x-ray.
Biopsy	During a biopsy, a provider collects a sample of cells for testing in the laboratory. In most situations, a biopsy is the only way to diagnose cancer definitively.

Goals of cancer treatment

Treatment	Goal
Primary treatment	The goal of a primary treatment is to completely remove cancer from the body or kill the cancer cells. Any cancer treatment can be used as a primary treatment, but the most common primary cancer treatment for the most common cancers is surgery. If a cancer is susceptible to radiation therapy or chemotherapy, these methods may be used as the primary treatment.
Adjuvant treatment	Adjuvant therapy aims to kill any cancer cells that may remain after primary treatment to reduce the cancer’s chance of recurrence. Any cancer treatment can be used as adjuvant therapy. Common adjuvant therapies include chemotherapy, radiation therapy, and hormone therapy.
Palliative treatment	Palliative treatments may relieve side effects of treatment or signs and symptoms caused by cancer itself. Surgery, radiation, chemotherapy, and hormone therapy can all be used to alleviate symptoms and control the spread of cancer when a cure isn’t possible. Medications may relieve symptoms such as pain and shortness of breath. Palliative treatment can be used at the same time as other treatments intended to cure the cancer.

Cancer treatment options

Treatment	Purpose
Surgery	The goal of surgery is to remove the cancer or as much of the cancer as possible.
Chemotherapy	Chemotherapy uses drugs to kill cancer cells.
Radiation therapy	Radiation therapy uses high-powered energy beams, such as x-rays and protons, to kill cancer cells. Radiation treatment can come from a machine outside the body (external beam radiation) or placed inside the body (brachytherapy).
Bone marrow transplant	Bone marrow transplant is also known as a stem cell transplant. A bone marrow transplant can use the patient’s own cells or cells from a donor to replace damaged or diseased bone marrow.
Immunotherapy	Immunotherapy, also known as biological therapy, uses the body’s immune system to fight cancer. Cancer can survive unchecked in the body because the immune system doesn’t recognize it as an intruder. Immunotherapy can help the immune system “see” cancer and attack it.
Hormone therapy	The body’s hormones fuel some types of cancer. Examples include breast cancer and prostate cancer. Removing those hormones from the body or blocking their effects may cause the cancer cells to stop growing.
Targeted drug therapy	Targeted drug treatment focuses on specific abnormalities within cancer cells that allow them to survive.



Questions?

Provider Education Series

Documentation & Coding for Risk Adjustment



Thank you!



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