



CMS Measure ID/CMS QCDR ID: CAP30

Measure Title: Urinary Bladder Biopsy Diagnostic Requirements For Appropriate Patient Management

<p>Measure Description</p>	<p>Percentage of urinary bladder carcinoma pathology reports that include the procedure, histologic tumor grade, histologic type, presence/absence of muscularis propria, presence/absence of lymphovascular invasion and extent of tumor invasion AND meet the maximum 2 business day turnaround time (TAT) requirement (Report Date – Accession Date ≤ 2 business days).</p> <p>INSTRUCTIONS: This measure has two performance rates that contribute to the overall performance score:</p> <ol style="list-style-type: none"> 1. Percent of cases for which all required data elements of the urinary bladder carcinoma pathology report are included. 2. Percent of cases that meet the maximum 2 business day turnaround time. <p>The overall performance score submitted is a weighted average of: (Performance rate 1 x 70%)+(Performance rate 2 x 30%)</p>
<p>Denominator Statement</p>	<p>Surgical pathology reports for bladder biopsies and transurethral resection of bladder tumor (TURBT) with a pathological diagnosis of carcinoma of the urinary bladder (urothelial carcinoma)</p> <p>CPT: 88305, 88307 AND ICD10:</p> <ul style="list-style-type: none"> • C67.0 Malignant neoplasm of trigone of bladder • C67.1 Malignant neoplasm of dome of bladder • C67.2 Malignant neoplasm of lateral wall of bladder • C67.3 Malignant neoplasm of anterior wall of bladder • C67.4 Malignant neoplasm of posterior wall of bladder • C67.5 Malignant neoplasm of bladder neck • C67.6 Malignant neoplasm of ureteric orifice • C67.8 Malignant neoplasm of overlapping sites of bladder • C67.9 Malignant neoplasm of bladder, unspecified <p>The denominator must be met between 01/01/2021 and 12/26/2021. This is to provide sufficient time for the performance of the numerator to be met within the performance period.</p>
<p>Denominator Exclusions</p>	<p>Urachal Carcinoma (ICD-10 C67.7)</p>
<p>Denominator Exceptions</p>	<p>Documentation of medical reason(s) for not including the required elements in the pathology report. For example:</p> <ul style="list-style-type: none"> • Specimen contains metastatic carcinoma (not a primary neoplasm)



Numerator Statement	<p>Urinary bladder carcinoma pathology reports that include</p> <ul style="list-style-type: none"> • Procedure • Histologic tumor grade • Histologic type • Presence/absence of muscularis propria • Presence/absence of lymphovascular invasion • Extent of tumor invasion <p>AND</p> <p>Final pathology report that is verified in the laboratory/hospital information system and available to the requesting physician(s) within 2 business days.</p>
Numerator Exclusions	<p>None</p>
Guidance	<p>Numerator definitions:</p> <ol style="list-style-type: none"> 1. Turnaround Time (TAT): The day the specimen is accessioned in the lab to the day the final report is signed out. Business days counted only. 2. Accession Date: The date recorded in the laboratory/hospital information system that documents when a specimen was received by the laboratory. 1. Report Date: The date recorded in the laboratory/hospital information system that documents when a result is verified the pathologist, reported by the laboratory information system and is available to the requesting physician(s) (signed out). 3. Signed Out/Verified: When a pathology report is released with a final diagnosis.
Measure Information	
NQS Domain	<p>Communication and Care Coordination</p>
Meaningful Measures Area(s)	<p>Transfer of Health Information and Interoperability</p>
Meaningful Measure Rationale	<p>The vast majority (more than 95%) of carcinomas of the urinary bladder, renal pelvis, and ureter are urothelial cell in origin, previously termed transitional cell cancer. Utilization of the most recent 2016 World Health Organization (WHO) classification of tumors of the urothelial tract and the updated AJCC (8th ed) TNM Staging System for carcinomas of the urinary bladder is recommended. (1) These cancers may be heterogeneous in histologic appearance, including adenocarcinoma, squamous cell carcinoma or small cell carcinoma elements; however, they should still be classified as urothelial carcinoma unless the cancer is composed entirely of the aforementioned histologic types (1-7). A cystoprostatectomy specimen may contain three separate primaries: carcinoma of the urinary bladder, carcinoma of the prostate and/or carcinoma of the urethra (3-5). Depending on the pathology in a given case, the classification, staging and protocol to use in a cystoprostatectomy specimen will vary (2).</p>



By AJCC convention, the designation “T” refers to a primary tumor that has not been previously treated (7). The symbol “p” refers to the pathologic classification of the TNM, as opposed to the clinical classification, and is based on gross and microscopic examination (7). Pathologic staging is usually performed after surgical resection of the primary tumor (6-7). pT entails a resection of the primary tumor or biopsy adequate to evaluate the highest pT category, pN entails removal of nodes adequate to validate lymph node metastasis, and pM implies microscopic examination of distant lesions (7). Clinical classification (cTNM) is usually carried out by the referring physician before treatment during initial evaluation of the patient or when pathologic classification is not possible (6-7).

Turnaround time (TAT) is an indicator of efficiency in anatomic pathology and may affect coordination of patient care. Timely pathology reports are one of the most important tools physicians use to adequately manage the quality and safety of patient care. The implication of surgical pathology report delay, as shown in research evidence, is that prolonged turnaround time can play a major role in disease complications, including raising morbidity and mortality rates. Therefore, verifying pathology reports in an appropriate timeframe helps healthcare practitioners with timely diagnosis and more effective treatment planning (8-10)

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2. Amin MB, Murphy WM, Reuter VE, et al. Controversies in the pathology of transitional cell carcinoma of the urinary bladder. In: Rosen PP, Fechner RE, eds. *Reviews of Pathology*. Vol. 1. Chicago, IL: ASCP Press; 1996.
3. Eble JN, Young RH. Carcinoma of the urinary bladder: a review of its diverse morphology. *Semin Diagn Pathol*. 1997;14(2):98-108.
4. Moch H, Humphrey PA, Ulbright TM, Reuter VE. *WHO Classification of Tumours of the Urinary System and Male Genital Organs*. Geneva, Switzerland: WHO Press; 2016.
5. Murphy WM, Grignon DJ, Perlman EJ. Tumors of the urinary bladder. In: *Tumors of the Kidney, Bladder, and Related Urinary Structures*. AFIP Atlas of Tumor Pathology Series 4. Washington, DC: American Registry of Pathology; 2004.
6. Epstein JI, Amin MB, Reuter VR, Mostofi FK, the Bladder Consensus Conference Committee. The World Health Organization/ International Society of Urological Pathology Consensus classification of urothelial (transitional cell) neoplasms of the urinary bladder. *Am J Surg Pathol*. 1998;22:1435-1448.
7. Amin MB, Edge SB, Greene FL, et al, eds. *AJCC Cancer Staging Manual*. 8th Ed. New York: Springer; 2017.
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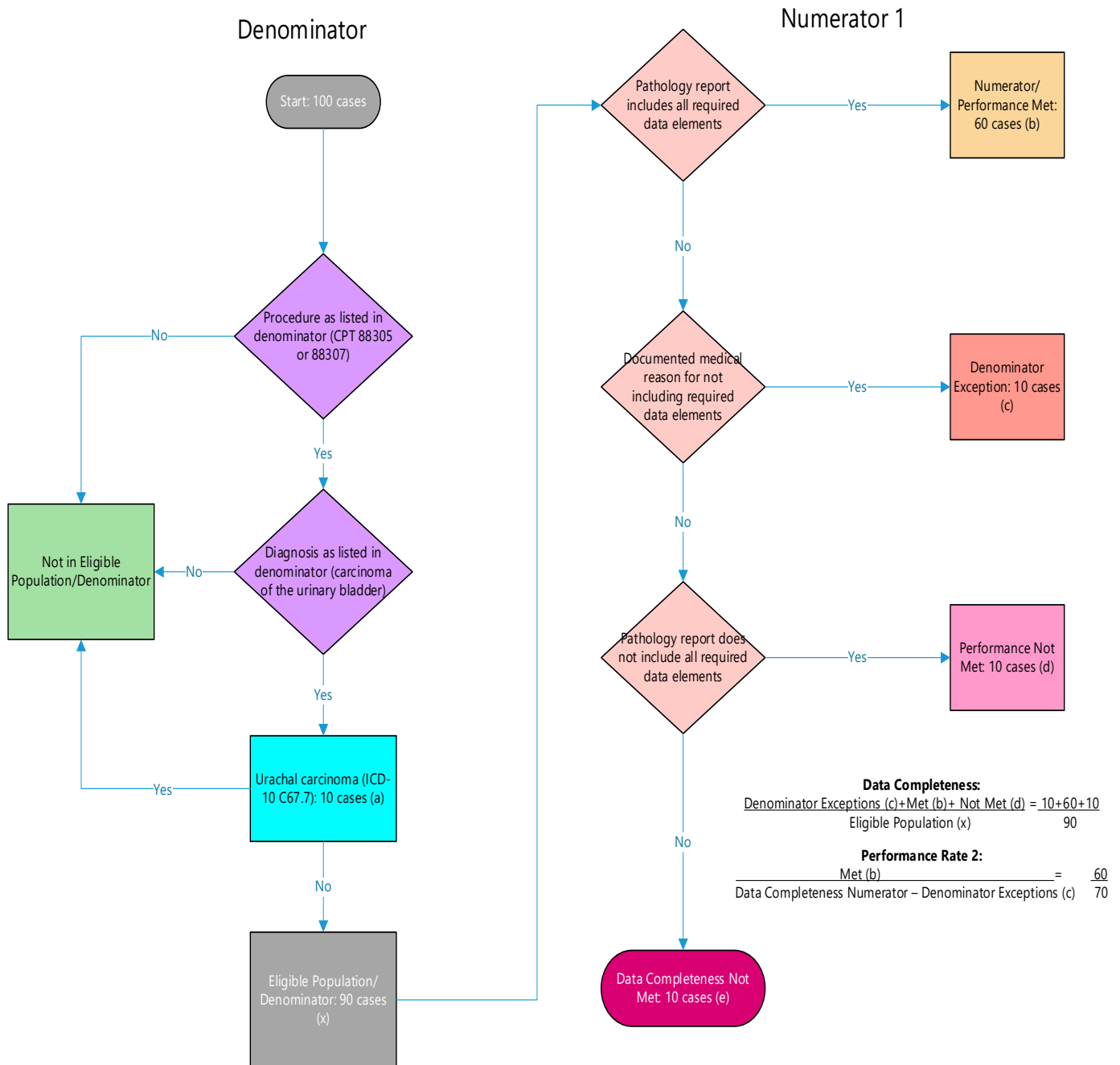


	<p>BMJ Qual Improv Rep. 2015 Nov 24;4(1). pii: u209223.w3773. doi: 10.1136/bmjquality.u209223.w3773. eCollection 2015.</p> <p>9. Volmar, KE et al. Turnaround Time for Large or Complex Specimens in Surgical Pathology: A College of American Pathologists Q-Probes Study of 56 Institutions. Archives of pathology & laboratory medicine. 139. 171-7. 10.5858/arpa.2013-0671-CP. 2015.</p> <p>10. Patel, S. et al. Factors that impact turnaround time of surgical pathology specimens in an academic institution. Hum Pathol. 2012 Sep;43(9):1501-5. doi: 10.1016/j.humpath.2011.11.010. Epub 2012 Mar 8.</p>
Measure Type	Process
Data Source	Laboratory Information Systems; pathology reports
Summary of Performance Gap Evidence	<p>Despite published guidelines indicating the necessity of complete reporting on urinary bladder carcinoma (1), recent studies still indicate gaps in the pathology report (2), with over 20% of reviewed reports lacking histology, grade, microscopic extent or presence vs absence of muscularis propria (3).</p> <ol style="list-style-type: none"> 1. Epstein JI, Amin MB, Reuter VR, Mostofi FK, the Bladder Consensus Conference Committee. The World Health Organization/ International Society of Urological Pathology Consensus classification of urothelial (transitional cell) neoplasms of the urinary bladder. Am J Surg Pathol. 1998;22:1435-1448. 2. Hansel, D. E., Miller, J. S., Cookson, M. S., & Chang, S. S. (2013). Challenges in the pathology of non-muscle-invasive bladder cancer: a dialogue between the urologic surgeon and the pathologist. <i>Urology</i>, 81(6), 1123–1130. doi:10.1016/j.urology.2013.01.027 3. Schroeck, F. R., Pattison, E. A., Denhalter, D. W., Patterson, O. V., DuVall, S. L., Seigne, J. D., ... Goodney, P. P. (2016). Early Stage Bladder Cancer: Do Pathology Reports Tell Us What We Need to Know?. <i>Urology</i>, 98, 58–63. doi:10.1016/j.urology.2016.07.040
Measure Owner	College of American Pathologists
NQF ID	N/A
Number of Performance Rates	1
Overall Performance Rate	1st Performance Rate
High-priority	Yes



Improvement Notation	Higher score is better
Care Setting and Specialty	Care Setting: Other—Laboratories; Telehealth not applicable Specialty: Pathology
Current Clinical Guideline the Measure is Derived From	Paner, GP et al. Protocol for the Examination of Biopsy and Transurethral Resection of Bladder Tumor (TURBT) Specimens From Patients With Carcinoma of the Urinary Bladder. v 4.0.2.0 (February 2020) https://documents.cap.org/protocols/cp-urinary-bladder-biopsy-20-4020.pdf

Measure Flow
Performance Rate 1





Performance Rate 2:

