AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Bladder Cancer

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Bladder cancer is the most common malignancy of the urinary tract and the **10th leading cause of cancer death in the United States.**[1] Approximately 90% of cases are urothelial carcinoma (transitional cell carcinoma), arising from the urothelial cells lining the bladder.[2] Disease is classified into non-muscle-invasive (NMIBC, ~70% of diagnoses) and muscle-invasive (MIBC, ~30%) with markedly different prognosis and management;[3] 5-year survival ranges from ~96% for NMIBC to ~5% for metastatic disease.[3]

ICD-10 Codes: Primary tumor: **C67.0** (trigone), **C67.1** (dome), **C67.2** (lateral wall), **C67.3** (anterior wall), **C67.4** (posterior wall), **C67.5** (bladder neck), **C67.6** (ureteric orifice), **C67.7** (urachus), **C67.8** (overlapping sites), **C67.9** (unspecified — avoid when subsite is documentable). Metastatic to bladder from elsewhere: **C79.11**. Traps: **D09.0** (CIS of bladder — does NOT map to HCC 22) and **Z85.51** (personal history — applies only after complete eradication and end of active surveillance). Hematuria workup codes: **R31.0** (gross), **R31.21** (asymptomatic microscopic), **R31.29** (other microscopic) — replace with **C67.x** once disease is confirmed.[4]

Prevalence and Burden: Estimated **84,530 new cases** and **18,870 deaths** projected in the United States in 2026.[1] Men are **three to four times** more likely to develop the disease than women, with a lifetime risk of **1 in 26** for men, and **1 in 88** for women.[5] The median age at diagnosis is 73 years; and **90% of cases occur in patients ≥55 years** — predominantly a Medicare-age malignancy.[6] Male-to-female incidence ratio 3–4:[1], yet **women present at more advanced stage (34% more likely to present with stage IV)** and carry significantly higher bladder cancer mortality when presenting with **UTI-like symptoms** (HR 1.37, 95% CI 1.10–1.71).[7] Recurrence among the highest of any solid tumor: 50–70% of NMIBC patients recur; 10–25% progress to MIBC within 5 years.[1,8]

HCC/RAF V28 Mapping

ICD-10 CODE(S)	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
C67.0–C67.8 (specific subsite)	HCC 22 — Bladder, Colorectal, and Other Cancers[7,8]	0.363[7]	**Active malignancy** confirmed by pathology or imaging with anatomic subsite from cystoscopy/TURBT report — trigone, dome, lateral wall, anterior wall, posterior wall, bladder neck, ureteric orifice, urachus, or overlapping sites[7,8]
C67.9 (unspecified)	HCC 22 — Bladder, Colorectal, and Other Cancers[7]	0.363	**AVOID**: avoid when pathology or operative report specifies subsite; PCPs should review cystoscopy/TURBT documentation to assign C67.0–C67.8 whenever the anatomic location is documented[7]

ICD-10 CODE(S)	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
C79.11(Secondary malignant neoplasm of bladder)	HCC 18 — Metastatic Cancer to Bone/Other[7]	2.341	Secondary malignant neoplasm **OF bladder from a known primary site** (e.g., colorectal, cervical, prostate metastatic to bladder); document both primary tumor site and secondary bladder involvement[7]
D09.0(Carcinoma in situ of bladder)	No HCC	—	**AVOID:** Carcinoma in situ (CIS) of bladder — flat, high-grade lesion — does NOT map to HCC 22. Commonly missed on initial diagnostics; update to C67.x if progression to invasive disease confirmed[1,7]
Z85.51(Personal history of malignant neoplasm of bladder)	No HCC	—	**AVOID:** Personal history of bladder cancer applies **ONLY** after complete eradication **AND** end of active surveillance/BCG maintenance/known residual tumor. Active surveillance and BCG maintenance always code as C67.x[7]

ABBREVIATIONS: HCC = Hierarchical Condition Category; CMS = Centers for Medicare & Medicaid Services; CNA = Community Non-Dual Eligible, Aged; CIS = carcinoma in situ; RAF = Risk Adjustment Factor; V28 = CMS-HCC Model Version 28; TURBT = transurethral resection of bladder tumor; BCG = Bacillus Calmette-Guérin. * Annual value illustrative at AAVBC representative MA base rate ~$10,402/year, applied at CMS-HCC 2024 model normalization factor 1.067 for PY2026; actual plan payment varies by county and contract; The impact of this condition varies across patient populations, particularly in individuals with disability, dual eligibility, or those receiving care in institutional settings

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

Risk-Adjusted Care Resources per Patient/Year

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

Bladder Cancer Specified	Bladder Cancer Unspecified	Secondary malignant neoplasm of bladder
~$3,776	**~$3,776**	**~$24,351**
HCC 22 · RAF 0.363 · per active patient/year	HCC 22 · RAF 0.363 · per active patient/year	HCC 18 · RAF 2.341 · per active patient/year

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. 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

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings (older adults, at-risk population)

There is currently no Medicare-covered population screening for bladder cancer, as USPSTF has assigned a Grade I (insufficient evidence) rating and no major organization recommends routine population-level screening. Clinically, **diagnosis relies on pattern recognition in at-risk individuals, particularly** those presenting with **hematuria** (gross or microscopic), persistent irritative voiding symptoms, age ≥60, smoking history, or other risk factors.[9,10]

TEST	COVERAGE	FREQUENCY	CPT CODE	CLINICAL INDICATION
Urinalysis with microscopy	Covered as diagnostic/E/M during workup	Symptom-prompted or risk-prompted	81001	**≥3 RBC/HPF** = microhematuria threshold per AUA/SUFU 2025; risk of bladder cancer **~4%** with microscopic hematuria and **~16.5%** with gross hematuria[9]
Diagnostic cystoscopy	Covered for evaluation of hematuria and other symptoms	Per AUA/SUFU risk stratum (intermediate/high)	52000	Direct visualization is the gold standard for bladder cancer diagnosis; required for AUA/SUFU intermediate- and **high-risk** microhematuria[8]
CT urogram	Covered for high-risk microhematuria or gross hematuria evaluation	Per risk stratification	74178	Upper-tract imaging adjunct for AUA/SUFU high-risk patients **(≥60, >25 RBC/HPF, >30 pack-years)**[9] and any patient with gross hematuria
Renal ultrasonography	Covered for hematuria workup	Per risk stratification	76770	Upper-tract imaging adjunct for AUA/SUFU intermediate-risk microhematuria[9]

TEST	COVERAGE	FREQUENCY	CPT CODE	CLINICAL INDICATION
Urine cytology	Covered for evaluation of suspected malignancy	Adjunct only — not screening	88162/ 88161	Pooled sensitivity 0.37 (95% CI 0.35–0.39); specificity 0.95.[9] AUA/SUFU 2025 **Strong Recommendation: do not** routinely use cytology to decide whether to perform cystoscopy[9]
Tobacco cessation counseling	Covered by Medicare Part B	Up to 8 sessions per 12-month period	99406/ 99407	Smoking is the single greatest **modifiable** risk factor: current smoker RR 3.14; population-attributable risk ~50%;[11] risk decreases ~40% after 4 years of cessation[11]
Advance care planning (AWV)	Covered under Part B; no copay during AWV	Annually + when goals change	99497/ 99498	Particularly important for advanced or metastatic disease — 5-year survival **~5%** in metastatic disease[1]

ABBREVIATIONS: AUA = American Urological Association; AWV = annual wellness visit; CI = confidence interval; CT = computed tomography; E/M = evaluation and management; HPF = high-power field; PAR = population-attributable risk; RBC = red blood cell; RR = relative risk; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; USPSTF = United States Preventive Services Task Force

CLINICAL PEARL: HEMATURIA

When hematuria is identified:

- Order urinalysis with microscopy
- Apply AUA/SUFU risk stratification
- Initiate urology referral

Do not order urine culture alone or prescribe antibiotics without a confirmed positive culture.

Subtle Early Signs in Older Adults (>65)

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Gross hematuria (any single episode)	Risk of malignancy is approximately **10%** in patients with gross hematuria; spontaneous resolution **does not exclude malignancy**, because hematuria can be intermittent in bladder cancer. Gross hematuria warrants **urology evaluation** regardless of patient age, sex, anticoagulant use, or recent menstruation[12]
Persistent or recurrent microscopic hematuria ≥3 RBC/HPF	Cancer probability is approximately **4% overall**, rising to **6.3%** in the **AUA/SUFU high-risk stratum**: age **≥60 years**, **>25 RBC/HPF**, or **>30 pack-years**. Apply **AUA/SUFU 2025 risk stratification** — Low, Intermediate, High — with **high-risk patients → cystoscopy + CT urogram**[9]
New-onset overactive bladder symptoms (frequency, urgency, dysuria) in patient ≥60[13]	**Carcinoma in situ (CIS)** may cause pollakisuria, and larger tumors may cause urgency; symptoms can be indistinguishable from idiopathic overactive bladder (OAB). **New-onset OAB symptoms** in patients **≥60 years** with bladder cancer risk factors should prompt **cystoscopy before or concurrent with OAB pharmacotherapy**[14]
Recurrent UTI without positive culture (women)	women are **2.32× more likely** to receive a UTI diagnosis before bladder cancer identification (OR **2.32**, 95% CI **2.07–2.59**), with a mean diagnostic delay of **85.4 days vs 73.6 days** in men (P<0.001). Repeated antibiotics without a **positive urine culture** is a red flag for **occult malignancy**[15]
Smoking history with persistent voiding symptoms	Current smoking is associated with increased bladder cancer risk (**RR 3.14**), and former smoking remains associated with elevated risk (**RR 1.83**). Risk falls by approximately **40% after 4 years of cessation**; smoking accounts for an estimated **~50% of bladder cancer cases** at the population level[11]
Anticholinergic/ antimuscarinic exposure with symptom improvement and no prior cystoscopy	**Protopathic bias** may occur when anticholinergic OAB therapy suppresses tumor-induced urinary symptoms and delays diagnosis by months to years.[16] In older adults, **anticholinergic burden** is independently associated with dementia risk (OR **1.49**).[17] The **SUFU 2022 white paper** supports preferential use of **β3 agonists** — **mirabegron** or **vibegron** — over anticholinergics in this population

ABBREVIATIONS: AUA = American Urological Association; CI = confidence interval; CIS = carcinoma in situ; CT = computed tomography; HPF = high-power field; OAB = overactive bladder; OR = odds ratio; PAR = population-attributable risk; RBC = red blood cell; RR = relative risk; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; UTI = urinary tract infection

Geriatric Risk Factors

FACTOR	RISK SIGNAL	NOTES
Current cigarette smoking	**RR 3.14** vs never-smoker; PAR ~50% of bladder cancer cases[11]	Single greatest **modifiable** risk factor; Medicare covers up to **8 cessation counseling sessions** per 12-month period; **~40%** risk reduction after 4 years of cessation[11]
Former smoking	**RR 1.83**[11]	Persistent elevated risk; reinforce cessation maintenance
Occupational exposure (dyes, rubber, paints, aromatic amines)	Variable elevated risk; latency 20–40 years[18]	Take occupational history at intake; **document exposure** for cumulative risk assessment
High fasting glucose/ metabolic syndrome[18]	**PAR 8.2%**[19]	Diabetic Medicare population is **high-impact**; coordinate glycemic management and cancer surveillance
Female sex (with hematuria or LUTS)	**aOR 1.40** (95% CI 1.34–1.46) for **>30-day referral delay from hematuria claim**;[20] **HR 1.37** for bladder-cancer mortality when presenting with UTI-like symptoms[7]	Women face structural diagnostic **delay**; repeated UTI coding **without** positive cultures is a red flag
Age ≥55 years	~10.3 additional diagnostic-delay days per 10-year increase in age (95% CI 5.5–15.1);[21] **>90% of cases occur in ≥55 years**[19]	**Lower** threshold for cystoscopy in older adults presenting with hematuria, dysuria, or new OAB symptoms
Higher Charlson comorbidity score	Independent association with urology referral delay in SEER-Medicare cohort[15]	Proactive referral pathways and case management **reduce** delay risk
Pre-existing relationship with urology	**aOR 0.83** (95% CI 0.79–0.87) — 17% reduction in referral-delay likelihood[22]	VBC case for proactive specialist relationships in **high-risk populations**
Black race	**66% more likely** to be diagnosed at stage **IV**[23]	Account for structural diagnostic-delay patterns in care planning and follow-up
Chronic bladder irritation (recurrent stones, indwelling catheter, Schistosoma)	Modest but consistent risk elevation; associated with squamous cell histology[13]	Address underlying irritant; consider **lower** threshold for evaluation if symptoms emerge

ABBREVIATIONS: aOR = adjusted odds ratio; CI = confidence interval; GBD = Global Burden of Disease; HR = hazard ratio; LUTS = lower urinary tract symptoms; OAB = overactive bladder; PAR = population-attributable risk; RR = relative risk; UTI = urinary tract infection; VBC = value-based care

AUA/SUFU 2025 Microhematuria Risk Stratification

When microhematuria is detected, patients should be stratified by risk using the AUA/SUFU framework below; low-risk patients may be managed with a repeat urinalysis in 6 months, while intermediate- and high-risk patients warrant further workup — **AAVBC recommends urinalysis as a low-cost first step for anyone who does not fall into the low-risk category.**

RISK STRATUM	CRITERIA	EVALUATION PATHWAY	CANCER INCIDENCE
Low risk	Men aged <40/Women aged <60; 3–10 RBC/HPF; never-smoker or <10 pack-years; no risk factors[9]	Repeat urinalysis in 6 months[9]	0.4%[9]
Intermediate risk	Men aged 40–59/Women aged ≥60; 11–25 RBC/HPF; 10–30 pack-years	Cystoscopy + renal ultrasonography[9]	1.0%[9]
High risk	Men or Women aged ≥60; >25 RBC/HPF; >30 pack-years; history of gross hematuria[9]	Cystoscopy + CT urogram[9]	6.3%[9]
Gross hematuria (any patient)	Visible blood in urine, any single episode, any patient aged ≥18	Cystoscopy + CT urogram + urology referral within 24–48 hours[9,24]	~16.5%[9]

ABBREVIATIONS: AUA = American Urological Association; CT = computed tomography; HPF = high-power field; RBC = red blood cell; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction

Diagnostic Thresholds

FINDING	THRESHOLD	CLINICAL ACTION	KEY CAUTION
Microhematuria	**≥3** RBC/HPF on microscopic urinalysis[9]	Risk-stratify using AUA/SUFU criteria; do not default to antibiotics	Patients on diuretics **may dilute below** threshold — repeat on concentrated specimen before excluding
Gross hematuria	Any single visible episode in **any adult ≥18**[9]	Urology referral + cystoscopy + CT urogram; do not defer	Intermittent or self-resolved hematuria still requires **full evaluation** — one negative UA does **not** exclude malignancy

FINDING	THRESHOLD	CLINICAL ACTION	KEY CAUTION
Urine cytology (positive)	High-grade **positive** result	Proceed to cystoscopy regardless of imaging	**A positive result still requires cystoscopy** to confirm, localize, and characterize the lesion — cytology alone does not determine stage or guide treatment[8]
Urine cytology (negative)	Any **negative** result	**Do not use to defer cystoscopy** in high-risk patients	Pooled sensitivity is only 0.37 — a negative result **does not** rule out bladder cancer[9,13]
Smoking history	≥10 pack-years → intermediate risk; >30 pack-years → high risk	Escalate evaluation pathway accordingly	Accounts for **~50%** of population-attributable risk[11,18]
Age + sex	Men ≥40/Women ≥60 → intermediate risk; **Men or Women ≥60 with other criteria → high risk**[9]	Apply AUA/SUFU 2025 risk stratum	2025 update shifted women's thresholds upward — use current criteria[9]
Recurrent UTI-like symptoms	Negative or non-concordant cultures after antibiotics	Urology referral; do not repeat antibiotics without confirmed positive culture	Women are **2.32×** more likely to receive a UTI diagnosis before bladder cancer is identified[15]

ABBREVIATIONS: AUA = American Urological Association; CIS = carcinoma in situ; CT = computed tomography; HPF = high-power field; HR = hazard ratio; OAB = overactive bladder; OR = odds ratio; RBC = red blood cell; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; UTI = urinary tract infection

Cardinal Symptoms

CLINICAL CLUE	WHY IT MATTERS	NEXT DIAGNOSTIC STEP
Gross hematuria — any single episode in any adult	Cancer probability ~16.5%;[9] intermittent **self-resolution does NOT exclude malignancy**	Urology referral within **24–48** hours;[9,24] pancreatic protocol cystoscopy + CT urogram; do not stop at urinalysis

CLINICAL CLUE	WHY IT MATTERS	NEXT DIAGNOSTIC STEP
Microscopic hematuria ≥3 RBC/HPF in patient ≥60	AUA/SUFU 2025 high-risk stratum; cancer probability 6.3%[9]	Cystoscopy + CT urogram; if smoker– cessation counseling at **same visit**
Repeated UTI diagnosis in a woman ≥50 without positive cultures[7]	**Women 2.32× more likely to receive UTI diagnosis before bladder cancer** identification (OR 2.32, 95% CI 2.07–2.59);[15] HR 1.37 for bladder-cancer mortality when presenting with UTI-like symptoms	**Urinalysis with microscopy**; if persistent hematuria or symptoms after appropriate antibiotic course, cystoscopy + CT urogram[9]
New-onset overactive bladder symptoms (frequency, urgency, dysuria) in patient ≥60 with smoking history[14]	**CIS induces pollakisuria and larger tumors induce urgency, indistinguishable from idiopathic OAB;**[14] anticholinergic therapy may mask symptoms (protopathic bias)	Consider cystoscopy **before** initiating OAB pharmacotherapy; if OAB therapy already started, refer for cystoscopy and do not assume the diagnosis is confirmed
Patient already on anticholinergic with symptom improvement but no prior cystoscopy	Protopathic bias — medication may be masking cancer symptoms; anticholinergic burden carries independent dementia risk (OR 1.49)[17]	Refer for **cystoscopy**;[16] consider switching to **β3 agonist** (mirabegron, vibegron) per SUFU 2022 white paper
Hematuria in patient on loop diuretics (furosemide, bumetanide, torsemide)	High urine output may dilute red blood cell concentration below the ≥3 RBC/HPF threshold, masking microscopic hematuria[18]	**Repeat urinalysis** on a concentrated specimen (first-morning void);[9] proceed with full workup if positive

ABBREVIATIONS: AUA = American Urological Association; CIS = carcinoma in situ; CT = computed tomography; HPF = high-power field; HR = hazard ratio; OAB = overactive bladder; OR = odds ratio; RBC = red blood cell; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; UTI = urinary tract infection

Common Oversights

OVERSIGHT/SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD
Attributing hematuria to UTI, anticoagulation, menstruation, or BPH without full workup	**Hematuria is intermittent in bladder cancer**; over **50%** of bladder cancer patients are initially **misdiagnosed**.[15,21] Any gross hematuria mandates urology evaluation regardless of comorbidities or anticoagulant use

OVERSIGHT/SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD
Treating presumed UTI repeatedly without positive culture in a woman ≥50[7]	Women **2.32×** more likely to receive UTI diagnosis before bladder cancer;[15] HR 1.37 bladder-cancer mortality when presenting with **UTI-like symptoms**. Repeated antibiotic prescriptions without positive cultures is a red flag for occult malignancy
Trusting a negative urine cytology to defer cystoscopy	Pooled cytology sensitivity is 0.37 (95% CI 0.35–0.39);[9] AUA/SUFU 2025 Strong Recommendation: do not routinely use cytology to decide whether to perform cystoscopy.[9] Cytology is an **adjunct only** — not a triage tool
Initiating anticholinergic OAB therapy in a patient ≥60 with new-onset symptoms and risk factors without cystoscopy	Protopathic bias — anticholinergics may **mask** tumor-induced symptoms and **delay** diagnosis; anticholinergic burden carries independent dementia risk. **Consider cystoscopy first**; consider β3 agonist instead of anticholinergic where pharmacotherapy is indicated[16,17]
Assuming low-risk NMIBC patients do not need follow-up	Low-grade tumors have **50–70% recurrence rate;**[1] surveillance cystoscopy at 3 and 12 months then annually is required per NCCN.[8] The 'low-risk' designation refers to upfront treatment intensity, not absence of surveillance

ABBREVIATIONS: BCG = Bacillus Calmette-Guérin; BPH = benign prostatic hyperplasia; CI = confidence interval; CIS = carcinoma in situ; HR = hazard ratio; HCC = Hierarchical Condition Category; NCCN = National Comprehensive Cancer Network; NMIBC = non-muscle-invasive bladder cancer; OAB = overactive bladder; OR = odds ratio; PCP = primary care provider; RAF = Risk Adjustment Factor; TURBT = transurethral resection of bladder tumor; UTI = urinary tract infection

Key Differentials in Elderly

PRESENTATION	DIFFERENTIAL	KEY TESTS
Gross hematuria	Bladder cancer **vs.** upper-tract urothelial carcinoma; nephrolithiasis; benign prostatic hyperplasia; prostate cancer; renal cell carcinoma; cystitis[9]	Urinalysis + microscopy; cystoscopy; CT urogram; PSA in men
Microscopic hematuria ≥3 RBC/HPF	Bladder cancer **vs.** upper-tract urothelial carcinoma; nephrolithiasis; BPH; glomerulonephritis; benign exercise-related hematuria	AUA/SUFU 2025 risk stratification → cystoscopy ± upper-tract imaging[9]
Frequency/urgency/dysuria — new onset in ≥60[13,14]	Bladder cancer (CIS) **vs.** idiopathic OAB; UTI; BPH; pelvic radiation cystitis	Urinalysis + culture; if persistent without positive culture → cystoscopy
UTI-like symptoms without positive culture	Bladder cancer (especially in women) **vs.** interstitial cystitis; urolithiasis[7,15]	Repeat urinalysis + culture; if persistent → cystoscopy + CT urogram[9]

PRESENTATION	DIFFERENTIAL	KEY TESTS
Pelvic/suprapubic pain with hematuria	Advanced bladder cancer (MIBC) **vs.** gynecologic malignancy; pelvic infection; nephrolithiasis[13]	Cystoscopy + CT urogram; gynecologic exam in women

ABBREVIATIONS: AUA = American Urological Association; BPH = benign prostatic hyperplasia; CIS = carcinoma in situ; CT = computed tomography; HPF = high-power field; MIBC = muscle-invasive bladder cancer; OAB = overactive bladder; PSA = prostate-specific antigen; RBC = red blood cell; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; UTI = urinary tract infection

Comorbidity Screening

CONDITION	PREVALENCE/ASSOCIATION	SCREENING APPROACH
Chronic kidney disease (N18.x)	Affects cisplatin eligibility; common in elderly and post-cystectomy patients[8]	**Annual eGFR + UACR**; document CKD stage; impacts MIBC treatment selection (cisplatin-eligible vs ineligible)
Diabetes mellitus/ metabolic syndrome (E11.x)	High fasting glucose PAR 8.2% (GBD 2021);[19] affects cisplatin nephrotoxicity risk	**HbA1c trend**; nephrotoxicity-risk assessment **before** cisplatin therapy[8]
Cognitive impairment/ dementia (F03.x, G30.x)	**Anticholinergic burden** associated with **dementia** (OR 1.49);[17] impacts BCG maintenance adherence and post-TURBT delirium risk	**Annual MoCA**; Mini-Cog before BCG induction in elderly per SIOG;[15] review anticholinergic use and switch to β3 agonist where indicated[19]
Anticholinergic/ antimuscarinic polypharmacy	Symptom-masking, falls risk, cognitive risk; OAB anticholinergics carry elevated dementia signal[17]	**Medication reconciliation at every visit**; deprescribe or switch to β3 agonist; reassess clinical need for OAB therapy
Tobacco use/nicotine dependence (F17.x)	Current smoking RR 3.14; PAR **~50%**;[11] active smoking at diagnosis worsens outcomes	**Tobacco-use screening every visit**; Medicare-covered cessation counseling up to 8 sessions per 12 months[13]
Depression (F32.x)	Common in chronic surveillance burden and after cystectomy/ urostomy creation[8]	**PHQ-2/PHQ-9** at every visit; coordinate with palliative care and behavioral health for advanced disease[8]

ABBREVIATIONS: BCG = Bacillus Calmette-Guérin; eGFR = estimated glomerular filtration rate; HbA1c = glycated hemoglobin; MoCA = Montreal Cognitive Assessment; OAB = overactive bladder; OR = odds ratio; PAR = population-attributable risk; PHQ = Patient Health Questionnaire; RR = relative risk; SIOG = International Society of Geriatric Oncology; TURBT = transurethral resection of bladder tumor; UACR = urine albumin-to-creatinine ratio

Staging — NMIBC vs MIBC

Bladder cancer is classified as **non-muscle-invasive (NMIBC) or muscle-invasive (MIBC)** based on the depth of tumor penetration into the bladder wall. Staging is determined by TURBT pathology and defines the treatment pathway. NMIBC is managed with intravesical therapy and structured surveillance. MIBC requires systemic chemotherapy and radical cystectomy. Apply this framework once bladder cancer is confirmed to guide treatment decisions and urology referral urgency.

CLASSIFICATION	CRITERIA/FEATURES	TREATMENT FRAMEWORK
NMIBC — Low risk	Solitary Ta, low-grade, ≤3 cm[25]	**Single-dose** intravesical chemotherapy within **24 h of TURBT** (gemcitabine or mitomycin, category 1);[25] surveillance cystoscopy at 3, 12 months, then annually;[8] reduces 5-year recurrence by ~35%
NMIBC — Intermediate risk	Multifocal; Ta low-grade >3 cm; rapid recurrence; T1 low-grade[8,25]	Intravesical BCG OR intravesical chemotherapy preferred; BCG induction (6 weekly instillations) + maintenance ideally **1 year per SWOG** protocol[25]
NMIBC — High risk (BCG-naïve)	T1; high-grade; CIS; recurrent high-grade Ta[8,10]	BCG induction + maintenance (category 1) for **3 years per SWOG**;[25] age alone does **not** contraindicate intravesical therapy per SIOG 2020[27]
NMIBC — BCG-unresponsive	Failure to respond to adequate BCG within 6–12 months[8]	Preferred: **radical cystectomy or clinical trial**. Other: nadofaragene firadenovec-vncg, nogapendekin alfa inbakicept + BCG, pembrolizumab if cystectomy-ineligible[8]
Muscle-invasive (MIBC) — Stage II/IIIA, cisplatin-eligible	T2–T4a, N0–N1, M0; eGFR adequate for cisplatin[8]	Neoadjuvant cisplatin-based chemotherapy + radical cystectomy + pelvic lymph node dissection (category 1);[8] **absolute survival benefit ~31 months** (SWOG 8710); adjuvant durvalumab FDA-approved[8]

CLASSIFICATION	CRITERIA/FEATURES	TREATMENT FRAMEWORK
MIBC — cisplatin-ineligible	eGFR <~50 mL/min or other contraindications to cisplatin[8]	Enfortumab vedotin + pembrolizumab followed by cystectomy (or cystectomy alone);[8] bladder-preservation chemoradiation + TURBT (category 1) for selected patients[8]
Metastatic (Stage IVB)	Distant metastases present[8]	First-line: **enfortumab vedotin + pembrolizumab** (preferred per NCCN; has replaced platinum-based chemo as primary 1L);[8] molecular testing recommended (FGFR alterations, MSI/dMMR, TMB-H)[8]

ABBREVIATIONS: BCG = Bacillus Calmette-Guérin; CIS = carcinoma in situ; dMMR = mismatch repair deficient; eGFR = estimated glomerular filtration rate; FGFR = fibroblast growth factor receptor; MIBC = muscle-invasive bladder cancer; MSI = microsatellite instability; NCCN = National Comprehensive Cancer Network; NMIBC = non-muscle-invasive bladder cancer; SIOG = International Society of Geriatric Oncology; SWOG = Southwest Oncology Group; TURBT = transurethral resection of bladder tumor; TMB-H = tumor mutational burden high

AAVBC PERSPECTIVE

Bladder cancer is a systematically delayed diagnosis, ***driven by predictable misattribution patterns****: hematuria attributed to UTI in women, BPH in older men, and anticoagulant use in patients on blood thinners. These patterns are measurable, documented, and preventable.* ***AAVBC supports a value-based care approach to bladder cancer that prioritizes early detection through rapid, structured evaluation of high-risk patients****. At low cost, urinalysis screening for hematuria and microhematuria combined with assessment of high-risk clinical features provides the foundation for timely identification. Primary care physicians are positioned to lead this effort: performing or ordering urinalysis at the point of care, coordinating swift urology referrals through patient-centered care teams, and implementing structured screening protocols that reduce unnecessary testing while ensuring high-risk patients are not missed. Proactive surveillance, reduced diagnostic delay, and active management of recurrence risk are the mechanisms through which value-based primary care improves long-term outcomes and manages downstream costs.*

3 MEAT DOCUMENTATION ESSENTIALS

Bladder cancer requires years of active management, and **documentation must reflect that clinical reality at every encounter.** The most common errors are using Z85.51 (personal history)

when a patient is still on BCG maintenance or under surveillance, defaulting to C67.9 when the pathology report specifies the tumor subsite, and treating D09.0 (carcinoma in situ) as equivalent to invasive disease. The MEAT framework below connects each documentation element to a concrete clinical action: monitoring cystoscopy and cytology trends, evaluating imaging and pathology findings, assessing the active diagnosis with subsite and stage, and treating with a documented regimen and urology coordination.

Case vignette: A 72-year-old patient with a 45-pack-year smoking history presents with one episode of gross hematuria 4 weeks ago that resolved spontaneously. Patient had a UTI 3 months ago, completed antibiotics, and was reassured. PCP recognizes the pattern, orders urinalysis (8 RBC/HPF), urine cytology, and refers urgently to urology. Cystoscopy 6 days later reveals a 2.5 cm papillary tumor on the lateral wall. TURBT shows high-grade T1 urothelial carcinoma. ECOG 1; G8 score 14 → CGA placed per SIOG 2020.[15]

MONITOR: Hematuria trajectory: single episode of **gross hematuria 4 weeks prior**; urinalysis confirmed **8 RBC/HPF**; no recurrence since TURBT. Smoking history: **45 pack-years**, active smoker; cessation counseling initiated. Renal function: **eGFR 62 mL/min (CKD stage 2)**; monitoring for cisplatin eligibility if disease progresses to MIBC. Performance status: **ECOG 1; G8 score 14**; CGA ordered. Anticholinergic burden: patient previously on oxybutynin for OAB; transitioned to mirabegron given bladder cancer diagnosis.

EVALUATE: Urinalysis with microscopy (5/14): **8 RBC/HPF; pyuria absent; nitrite negative**. Urine cytology (5/14): negative — insufficient to exclude malignancy in high-risk presentation; cystoscopy proceeded. Cystoscopy (5/20): **2.5 cm** papillary tumor, left lateral wall. TURBT pathology (5/24): **high-grade T1 urothelial carcinoma**; muscle invasion not identified on initial specimen; re-TURBT planned. CT urogram (5/22): **no upper-tract lesions; no lymphadenopathy.**

ASSESS: High-risk non-muscle-invasive urothelial carcinoma, left lateral wall: **C67.2** (active malignancy). Current tobacco use disorder: **F17.210**. **CKD stage 2: N18.2**. Overactive bladder: **N32.81** (oxybutynin discontinued; mirabegron initiated).

TREAT: Re-TURBT scheduled for completion of staging. Plan: **BCG induction** (6 weekly instillations) followed by **3-year SWOG-protocol** maintenance for high-risk NMIBC, pending re-TURBT results. Supportive care: mirabegron substituted for oxybutynin; tobacco cessation counseling initiated (Medicare-covered, up to 8 sessions per 12 months). Referrals: urology (active), multidisciplinary urothelial cancer clinic, tobacco cessation program, registered dietitian. Surveillance plan: **cystoscopy every 3 months for 2 years**, **then every 6 months for 2 years, then annually.**

Clinical Documentation Elements

- **Specify anatomic subsite:** Document **“urothelial carcinoma of the lateral wall (C67.2)”** rather than **“bladder cancer”** or **C67.9**; Cystoscopy and transurethral resection of bladder tumor (TURBT) reports usually specify location; PCPs should review specialist notes to assign **C67.0–C67.8** when supported
- **Active vs personal history:** Use **C67.x** while disease is **active**, under **surveillance**, receiving **BCG maintenance**, or associated with **residual tumor**; **Z85.51** applies only after complete eradication and completion of active surveillance; this is one of the most consequential coding errors in bladder cancer documentation

- **Document CIS distinctly: D09.0** for carcinoma in situ (CIS) **does not map to HCC 22**; Document pathology confirming **CIS/Tis** and update to **C67.x** if progression to invasive disease is confirmed
- **Link comorbidities to treatment eligibility:** Document **CKD stage**, which affects cisplatin eligibility; **cognitive impairment**, which may affect feasibility of BCG maintenance; and **anticholinergic burden**, which may support substitution with **mirabegron** or **vibegron**
- **Document performance and frailty:** Record **ECOG performance status** and **G8 score**, with comprehensive geriatric assessment (CGA) findings when triggered; CGA-stratified prognosis in metastatic urothelial cancer: median overall survival **18.5 months** in fit patients vs **10.8 months** in vulnerable patients vs **3.8 months** in frail patients

Reframing Common Documentation Shortcuts

INSTEAD OF…	DOCUMENT…
'Bladder cancer'	'High-grade T1 urothelial carcinoma of the left lateral wall **(C67.2)**, confirmed by TURBT [date]; AUA/SUO high-risk NMIBC; BCG induction planned'
'History of bladder cancer' (in a patient on active BCG maintenance)	'Active urothelial carcinoma on BCG maintenance — **C67.2**' (Z85.51 applies only after complete eradication and end of active surveillance)
'CIS of bladder' (treated as same as invasive)	'Carcinoma in situ of bladder, flat lesion confirmed by TURBT pathology [date] — **D09.0**' (NOT mapped); document plan for close cystoscopy surveillance; update to **C67.x if progression**
'On BCG'	'BCG induction, instillation 4 of 6 for high-risk T1 urothelial carcinoma **(C67.2)**; tolerating with grade 1 dysuria, no fever, no BCG sepsis signs'
'Recurrent UTI'	'Recurrent UTI symptoms without positive culture × 3 episodes over 6 months in patient ≥60 with smoking history; pyuria absent on most recent UA; cystoscopy + CT urogram ordered per AUA/SUFU high-risk pathway'
'OAB'	'New-onset overactive bladder symptoms in patient ≥60 with 45 pack-year smoking history; cystoscopy completed prior to OAB therapy to exclude underlying tumor; β3 agonist (mirabegron) preferred over anticholinergic given dementia-risk profile in this age group'

INSTEAD OF…	DOCUMENT…

ABBREVIATIONS: AUA = American Urological Association; AUA/SUO = AUA/Society of Urologic Oncology; BCG = Bacillus Calmette-Guérin; CIS = carcinoma in situ; CT = computed tomography; HCC = Hierarchical Condition Category; NMIBC = non-muscle-invasive bladder cancer; OAB = overactive bladder; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; TURBT = transurethral resection of bladder tumor; UA = urinalysis; UTI = urinary tract infection

DOCUMENTATION IS COMPREHENSIVE CODING

Every active bladder cancer encounter should state the diagnosis with **anatomic subsite** ('**C67.2 lateral wall**'), record **AUA/SUO NMIBC risk stratum** or MIBC stage, describe the **active management plan** (BCG induction/maintenance, surveillance cystoscopy interval, intravesical chemotherapy, systemic therapy), and list **comorbidity linkages** (CKD stage for cisplatin eligibility, cognitive screen for BCG maintenance, tobacco cessation for ongoing risk-reduction). **Z85.51** applies only after complete eradication and **end of active surveillance** — using it for surveillance or BCG-maintained patients understates clinical complexity and impairs continuity across primary care and urology

4 TREATMENT AND REFERRAL QUICK GUIDE

Treatment in bladder cancer is driven by NMIBC vs MIBC classification, risk stratification, and renal/functional fitness, not chronological age. NCCN Bladder Cancer v1.2026 organizes intravesical therapy, radical cystectomy, neoadjuvant/adjuvant systemic therapy, bladder preservation, and metastatic-line therapy by stage and biomarker status.[8] The primary care role encompasses hematuria recognition and rapid referral, comorbidity management that affects treatment eligibility, smoking cessation as a continuous active intervention, and continuity through chronic surveillance. Measurement-based care anchors shared decision-making; cystoscopy interval adherence, cytology and imaging trends, eGFR, and G8/CGA in older adults.[8,26,27]

Therapy Escalation Criteria

TRIGGER	ACTION*
Gross hematuria (any single episode)	Urology referral within **24–48 hours**;[9,24] cystoscopy + CT urogram; **do not stop at urinalysis or rely on negative cytology**
AUA/SUFU intermediate-risk microhematuria	Cystoscopy + renal ultrasonography;[9] **smoking cessation counseling** at same visit[11]
AUA/SUFU high-risk microhematuria (≥60, >25 RBC/HPF, >30 pack-years)[9]	Cystoscopy + CT urogram;[9] urology referral[9]

TRIGGER	ACTION*
Low-risk NMIBC (solitary Ta, low-grade, ≤3 cm)	**Single-dose** intravesical chemotherapy within 24 h of TURBT (gemcitabine or mitomycin, category 1);[25] cystoscopy at 3, 12 months, then annually[8]
Intermediate-risk NMIBC	**Intravesical BCG** or **chemotherapy** (preferred);[25] BCG induction (**6 weekly** instillations) + maintenance **1 year** per SWOG
High-risk NMIBC (BCG-naïve)	**BCG induction** + maintenance for **3 years** per SWOG;[25] age alone does not contraindicate per SIOG 2020; Mini-Cog and G8 before treatment decisions in elderly[27]
BCG-unresponsive NMIBC	Preferred: **radical cystectomy or clinical trial**. Other: nadofaragene firadenovec-vncg, nogapendekin alfa inbakicept + BCG, pembrolizumab if cystectomy-ineligible[8]
MIBC (T2–T4a, cisplatin-eligible)	Neoadjuvant cisplatin-based chemotherapy + radical cystectomy + pelvic lymph node dissection (category 1);[8] adjuvant durvalumab FDA-approved[8]
MIBC (cisplatin-ineligible)	Enfortumab vedotin + pembrolizumab followed by cystectomy;[8] or bladder-preservation chemoradiation + TURBT (category 1) for selected patients[8]
Metastatic (Stage IVB)	**First-line enfortumab vedotin + pembrolizumab** (preferred per NCCN; has replaced platinum-based chemo as primary 1L);[8] molecular testing for FGFR alterations, MSI/dMMR, TMB-H[8]

ABBREVIATIONS: AUA = American Urological Association; BCG = Bacillus Calmette-Guérin; CT = computed tomography; dMMR = mismatch repair deficient; FGFR = fibroblast growth factor receptor; HPF = high-power field; MIBC = muscle-invasive bladder cancer; MSI = microsatellite instability; NCCN = National Comprehensive Cancer Network; NMIBC = non-muscle-invasive bladder cancer; RBC = red blood cell; SIOG = International Society of Geriatric Oncology; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; SWOG = Southwest Oncology Group; TMB-H = tumor mutational burden high; TURBT = transurethral resection of bladder tumor
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

NCCN-Aligned First-Line Therapy by Disease Stage

DISEASE STAGE	PREFERRED THERAPY	KEY NOTES
NMIBC Low risk	Single-dose intravesical chemotherapy (gemcitabine or mitomycin) within **24 h of TURBT** (category 1)[8,25]	Reduces 5-year recurrence by **~35%**;[25] no maintenance BCG indicated; **surveillance cystoscopy** at 3, 12 months, then annually[8]

DISEASE STAGE	PREFERRED THERAPY	KEY NOTES
NMIBC Intermediate risk	**Intravesical BCG or chemotherapy preferred**; BCG induction (6 weekly) + maintenance ideally 1 year per SWOG[25]	**BCG availability** should factor into decision-making; switch to gemcitabine intravesical or mitomycin if BCG-supply constrained
NMIBC High risk (BCG-naïve)	BCG induction + maintenance for 3 years per SWOG;[25] category 1 for patients without very-high-risk features	**Age alone does not contraindicate intravesical therapy** per SIOG 2020;[27] Mini-Cog and G8 before treatment decisions
MIBC cisplatin-eligible	Neoadjuvant cisplatin-based chemo (gemcitabine + cisplatin or dose-dense MVAC) + radical cystectomy + PLND (category 1);[8] **absolute survival benefit ~31 months** (SWOG 8710)	**Adjuvant durvalumab** FDA-approved;[8] Onco-MPI in real-world geriatric cohort stratifies prognosis[25]
MIBC cisplatin-ineligible	Enfortumab vedotin + pembrolizumab followed by radical cystectomy; or bladder-preservation chemoradiation + TURBT (category 1) for selected patients[8]	CARG and CRASH chemotherapy **toxicity calculators** recommended;[26] immunotherapy tolerability appears similar in older vs younger patients[27]
Metastatic (Stage IVB)	**Enfortumab vedotin + pembrolizumab** — first-line; has replaced platinum-based chemo as primary 1L per NCCN[8]	Molecular testing recommended (FGFR alterations → erdafitinib; MSI-H/dMMR/TMB-H → pembrolizumab continuation; HER2 → T-DXd)[8]

ABBREVIATIONS: BCG = Bacillus Calmette-Guérin; CARG = Cancer and Aging Research Group; CRASH = Chemotherapy Risk Assessment Scale for High-Age Patients; dMMR = mismatch repair deficient; FGFR = fibroblast growth factor receptor; HER2 = human epidermal growth factor receptor 2; MIBC = muscle-invasive bladder cancer; MSI = microsatellite instability; MVAC = methotrexate, vinblastine, doxorubicin, cisplatin; NCCN = National Comprehensive Cancer Network; NMIBC = non-muscle-invasive bladder cancer; Onco-MPI = Oncological Multidimensional Prognostic Index; PLND = pelvic lymph node dissection; SIOG = International Society of Geriatric Oncology; SWOG = Southwest Oncology Group; TMB-H = tumor mutational burden high; TURBT = transurethral resection of bladder tumor; T-DXd = fam-trastuzumab deruxtecan-nxki *__Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions__

Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Tobacco cessation counseling	Active smoking cessation at diagnosis and through surveillance — primary modifiable risk factor	Medicare covers up to **8 sessions per 12-month period**;[11] **~40%** risk reduction after 4 years of cessation;[11] active smoking worsens outcomes
Surveillance cystoscopy adherence	Every 3 months × 2 years, every 6 months × 2 years, then annually for low- to intermediate-risk NMIBC[8]	Lifelong obligation for many patients; recurrence rate **50–70%** in NMIBC;[13] coordinate primary care visits with urology surveillance schedule
Anticholinergic-burden reduction	Switch from oxybutynin/tolterodine to mirabegron or vibegron where pharmacotherapy is indicated[16,17]	SUFU 2022 white paper supports **β3 agonists over anticholinergics in older adults**;[16] reduces dementia-risk burden and protopathic-bias risk
Comprehensive geriatric assessment	G8 ≤14 → CGA per SIOG 2020;[27] CGA-stratified prognosis in metastatic urothelial cancer (mOS 18.5 vs 10.8 vs 3.8 months)[26]	**Mini-Cog before BCG maintenance** and pre-operative planning; CARG and CRASH calculators for chemotherapy toxicity risk
Prehabilitation before radical cystectomy	Functional optimization, nutritional support, smoking cessation, anemia correction	TURBT complication rate up to **20% in elderly**;[27] **postoperative delirium** is the most common surgical complication and can cause **permanent** cognitive decline
Urostomy and catheter care education	**At-home stoma management** for ileal conduit; post-cystectomy continence support[8]	Caregiver education **reduces readmission rates**; coordinate with wound/ostomy nurse
Advance care planning	Document advance directives, surrogate decision-maker, code status during AWV	CPT 99497/99498 covered with no copay during AWV;[8] especially important for metastatic disease (5-year survival ~5%)[1]

INTERVENTION	TARGET/RECOMMENDATION	NOTES
BCG maintenance adherence monitoring	Active monitoring of instillation completion, tolerance, and warning signs throughout 1–3 year maintenance course; Mini-Cog before induction; assess transportation and caregiver support	BCG maintenance is an active, ongoing treatment requiring clinical management — not a passive surveillance activity; incomplete therapy is a clinical failure with direct staging consequences

ABBREVIATIONS: AWV = annual wellness visit; BCG = Bacillus Calmette-Guérin; CARG = Cancer and Aging Research Group; CGA = comprehensive geriatric assessment; CRASH = Chemotherapy Risk Assessment Scale for High-Age Patients; G8 = Geriatric 8; mOS = median overall survival; NMIBC = non-muscle-invasive bladder cancer; SIOG = International Society of Geriatric Oncology; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; TURBT = transurethral resection of bladder tumor

Medication Safety and Key Interactions

DRUG/CLASS	INTERACTION/TOXICITY*	CLINICAL ACTION*
Cisplatin (neoadjuvant/ adjuvant MIBC)	Nephrotoxicity, ototoxicity, peripheral neuropathy, severe nausea; requires **eGFR ≥60 mL/min** typically[8]	**Coordinate eGFR check** with oncology; aggressive hydration; monitor renal function and Mg/K throughout therapy
BCG intravesical	**BCG sepsis** (rare but life-threatening); local cystitis; dysuria; risk of BCG dissemination in immunocompromised[25]	Avoid in active TB, immunosuppression, severe cystitis; coordinate with urology if fever or systemic symptoms emerge during induction
Enfortumab vedotin + pembrolizumab (1L metastatic/cisplatin-ineligible MIBC)	Skin reactions, peripheral neuropathy, hyperglycemia (EV-related); immune-related adverse events (pembrolizumab — colitis, pneumonitis, hepatitis, endocrinopathies)[8]	**Monitor glucose during EV**; immediate evaluation of immune-related AEs; coordinate steroid management with oncology
Anticholinergic/ antimuscarinic OAB agents (oxybutynin, tolterodine, solifenacin, darifenacin)	Cumulative **anticholinergic burden associated with dementia** (OR 1.49);[17] falls and cognitive risk in older adults; symptom-masking (protopathic bias) in undiagnosed bladder cancer	Switch to **β3 agonist** (mirabegron or vibegron) where OAB therapy is indicated per SUFU 2022;[16] reassess clinical need at every visit

DRUG/CLASS	INTERACTION/TOXICITY*	CLINICAL ACTION*
β3 agonists (mirabegron, vibegron)	Hypertension (mirabegron > vibegron); **fewer cognitive harms** than anticholinergics[28]	Monitor BP at **initiation** and at **every visit**; preferred over anticholinergics in older adults with OAB symptoms[16]
Anticoagulants (warfarin, DOACs, antiplatelet agents)	Do NOT attribute hematuria to anticoagulation without full workup[9,24]	Per AUA/SUFU 2025 and ACP 2016: hematuria on anticoagulation still warrants risk-stratified evaluation
Diuretics	Urinary dilution may mask microscopic hematuria by lowering RBC concentration below threshold[18]	**Repeat urinalysis on concentrated specimen** (first-morning void) if clinical suspicion is high

ABBREVIATIONS: 1L = first-line; ACP = American College of Physicians; AE = adverse event; AUA = American Urological Association; BCG = Bacillus Calmette-Guérin; BP = blood pressure; DOAC = direct oral anticoagulant; eGFR = estimated glomerular filtration rate; EV = enfortumab vedotin; MIBC = muscle-invasive bladder cancer; OAB = overactive bladder; OR = odds ratio; RBC = red blood cell; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; TB = tuberculosis
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

When to Refer

CRITERION	SPECIALIST	URGENCY
Massive gross hematuria with clot retention; acute retention; urosepsis[8]	Emergency department/ urology	Emergent
Any single episode of gross hematuria[9,24]	Urology	**Urgent** (within 24–48 hours)
AUA/SUFU high-risk microhematuria[9]	Urology for cystoscopy + CT urogram	**Urgent** (within 1–2 weeks)
Confirmed NMIBC[8]	Urology for intravesical therapy; multidisciplinary clinic	**Urgent** — within 1–2 weeks
Confirmed MIBC[8]	Medical oncology, urologic oncology, radiation oncology multidisciplinary team	**Urgent** — within 1 week
G8 ≤14 in older adult, polypharmacy, frailty signals[25]	Geriatric oncology/ comprehensive geriatric assessment	**Urgent** (before next treatment)

CRITERION	SPECIALIST	URGENCY
Advanced or metastatic disease, symptom burden[8]	Palliative care	Routine — within 30 days
End-of-life trajectory, hospice eligible[8]	Hospice (Medicare Hospice Benefit)	When goals align

ABBREVIATIONS: AUA = American Urological Association; CT = computed tomography; G8 = Geriatric 8 screening tool; MIBC = muscle-invasive bladder cancer; NMIBC = non-muscle-invasive bladder cancer; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction

Follow-Up Timing — Surveillance

STAGE/CATEGORY	FREQUENCY	LABS/MONITORING
NMIBC Low risk	Cystoscopy at 3, 12 months, then annually[8]	**Urinalysis** at each visit; no routine cytology required for low risk
NMIBC Intermediate risk	Cystoscopy every 3 months × 2 years, every 6 months × 2 years, then annually[8]	**Urinalysis + cytology** at cystoscopy intervals; upper-tract imaging every **1–2 years**
NMIBC High risk	Cystoscopy every 3 months × 2 years, every 6 months × 2 years, then annually[8]	**Urinalysis + cytology** every 3–6 months; upper-tract imaging every 1–2 years[8]
Post-cystectomy MIBC	CT abdomen/pelvis and chest every 3–6 months × 2 years, then annually[8]	**Renal function** (eGFR); urine cytology of upper tract; metabolic panel; nutritional and continence support[8]
Metastatic, active systemic therapy	Imaging every 8–12 weeks; symptom-based reassessment[8]	CBC; CMP; renal function; immune-related AE surveillance; ECOG; G8 in older adults[8,26]

ABBREVIATIONS: AE = adverse event; CBC = complete blood count; CMP = comprehensive metabolic panel; CT = computed tomography; ECOG = Eastern Cooperative Oncology Group; eGFR = estimated glomerular filtration rate; G8 = Geriatric 8; MIBC = muscle-invasive bladder cancer; NMIBC = non-muscle-invasive bladder cancer

Comorbidity Management — Primary Care Role

COMORBIDITY	APPROACH	CAUTION
Tobacco use (F17.x)	**Tobacco-use screening** at every visit; Medicare-covered counseling up to 8 sessions/12 months[11]	**Active smoking** at diagnosis **worsens** outcomes; reinforce cessation through surveillance

COMORBIDITY	APPROACH	CAUTION
CKD (N18.x)	**Annual eGFR + UACR**; nephrotoxicity-risk assessment before cisplatin therapy[8]	**CKD progression** after cystectomy is a **chronic-management issue**; coordinate nephrology referral when needed
Anticholinergic/OAB burden	**Switch to β3 agonist** (mirabegron, vibegron) where OAB therapy is indicated; [16] medication reconciliation each visit	**Anticholinergic-burden** independently associated with **dementia** (OR 1.49);[17] protopathic bias may mask undiagnosed bladder cancer
Diabetes (E11.x)	HbA1c trend; nephrotoxicity-risk assessment[8]	High fasting glucose PAR **8.2% for bladder cancer**;[4] coordinate glycemic management during chemotherapy
Cognitive impairment (F03.x, G30.x)	**Mini-Cog before BCG induction** in elderly per SIOG;[27] annual MoCA; review medications for anticholinergic burden	**Cognitive impairment affects BCG maintenance adherence**; postoperative delirium risk after TURBT[27]
Depression (F32.x)	**PHQ-2/PHQ-9** at every visit; coordinate with palliative care and behavioral health[29]	Surveillance burden + **body-image change** after cystectomy/urostomy **increase depression risk**

ABBREVIATIONS: BCG = Bacillus Calmette-Guérin; CKD = chronic kidney disease; eGFR = estimated glomerular filtration rate; HbA1c = glycated hemoglobin; MoCA = Montreal Cognitive Assessment; OAB = overactive bladder; OR = odds ratio; PAR = population-attributable risk; PHQ = Patient Health Questionnaire; SIOG = International Society of Geriatric Oncology; TURBT = transurethral resection of bladder tumor; UACR = urine albumin-to-creatinine ratio

Cost-Smart Options

BRAND (EST. COST)	GENERIC/ALTERNATIVE (EST. COST)	MO. SAVINGS	COST-SMART TIP
Brand antimuscarinic OAB agents — oxybutynin XL (~$105/mo); tolterodine ER (~$70/mo)[30]	Generic immediate-release oxybutynin (~$10–45/mo);[30] generic mirabegron (~$190–212/mo);[31] vibegron/Gemtesa (~$501/mo WAC)[32]	~$60–95/mo switching to generic IR oxybutynin	**β3 agonists preferred over anticholinergics** in older adults per SUFU 2022; anticholinergic burden associated with 65% increased dementia risk at cumulative exposures >1,095 standardized daily doses[17]
Branded BCG — Tice (~$208/instillation);[31] **TheraCys (~$186/instillation);**[33] **6-week induction ≈ $1,200–1,300 drug cost (excludes administration)**	Generic intravesical gemcitabine or mitomycin C (lower cost than BCG; pricing varies by institution); BCG induction + SWOG maintenance remains standard when available	~$900–1,100/induction course	**Intravesical gemcitabine** is an established alternative under BCG shortages[8]
Padcev (enfortumab vedotin) ~$2,909/20 mg vial[33] **+ Keytruda (pembrolizumab) ~$11,115/every 3 weeks; est. annual cost >$500,000**[34]	No generic alternative — biosimilar landscape limited	—	**First-line preferred regimen** for metastatic urothelial carcinoma per NCCN;[8] biosimilar pathway may expand
Conventional fractionated radiotherapy (bladder preservation) — est. $10,000–30,000+/course (varies by facility and fractions)[34]	SBRT not standard for bladder; conventional fractionation remains the bladder-preservation backbone	Variable	**Bladder-preservation chemoradiation** is a high-value alternative to cystectomy in selected medically inoperable patients[8]

BRAND (EST. COST)	GENERIC/ALTERNATIVE (EST. COST)	MO. SAVINGS	COST-SMART TIP

ABBREVIATIONS: BCG = Bacillus Calmette-Guérin; ER = extended release; NCCN = National Comprehensive Cancer Network; OAB = overactive bladder; SBRT = stereotactic body radiotherapy; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; SWOG = Southwest Oncology Group; WAC = Wholesale Acquisition Cost; XL = extended release

Patient Education and Adherence

Bladder cancer carries a lifelong surveillance burden, body-image change (urostomy after cystectomy), and ongoing tobacco-cessation imperative. Patient education touchpoints should cover: the diagnosis and stage in plain language; surveillance cystoscopy schedule (every 3 months for first 2 years for intermediate/high risk); BCG instillation expectations (dysuria, mild cystitis), warning signs of BCG sepsis (fever, systemic symptoms — emergent evaluation); smoking cessation as a continuous active intervention (Medicare-covered up to 8 sessions/12 months);[13] anticholinergic-burden awareness (cognitive risk, protopathic bias);[16,17] urostomy and catheter self-care after cystectomy; and advance care planning

Quality Metrics Tie-In

MEASURE	TARGET	NOTES
Tobacco Use Screening and Cessation (MIPS #226)[11,35]	Tobacco-use screening at every visit; cessation counseling for users[13]	**Smoking** is the single greatest **modifiable risk factor** for bladder cancer (PAR ~50%)[11]
Care for Older Adults (HEDIS COA) — Stars: Medication Review 1x weight; Pain Assessment 1x weight (retiring 2027 Stars)[36]	Functional status, medication review, pain assessment, advance care planning — annually[27]	Cross-cutting measure relevant to **geriatric bladder cancer patients**; anticholinergic review especially important
Medication Reconciliation Post-Discharge (HEDIS MRP) — Stars: 1x weight; retiring from Stars 2027[36]	Reconciliation within 30 days of inpatient discharge[16]	**Critical after cystectomy**/TURBT; polypharmacy review for anticholinergics and nephrotoxic agents
Plan All-Cause Readmissions (CMS Stars PCR) — Stars: 3x weight, Outcome Measure[36]	30-day readmission rate[8]	**Cystectomy** carries **high readmission rates** in elderly; BCG complications may prompt emergency visits
Comprehensive Diabetes Care (HEDIS CDC) — Stars: Blood Sugar Controlled 3x weight; Eye Exam 1x weight[36]	HbA1c control and documentation[14]	High fasting glucose PAR **8.2%** for bladder cancer (GBD 2021); relevant for cisplatin nephrotoxicity assessment

MEASURE	TARGET	NOTES
Advance Care Planning (MIPS #47)[8,37]	Document advance directives, surrogate, code status[8]	Essential for advanced/metastatic disease (5-year survival ~5%);[18] CPT 99497/99498 covered during AWV

ABBREVIATIONS: AWV = annual wellness visit; CDC = Comprehensive Diabetes Care; CMS = Centers for Medicare & Medicaid Services; COA = Care for Older Adults; GBD = Global Burden of Disease; HbA1c = glycated hemoglobin; HEDIS = Healthcare Effectiveness Data and Information Set; MIPS = Merit-based Incentive Payment System; MRP = Medication Reconciliation Post-Discharge; PAR = population-attributable risk; PCR = Plan All-Cause Readmissions

QUALITY OUTCOME:

When primary care recognizes **hematuria** immediately, applies **AUA/SUFU 2025 risk stratification**, refers to urology within **24–48 hours for gross hematuria**, coordinates anticholinergic-burden reduction and CKD comorbidity management, and reinforces **smoking cessation** through surveillance, patients experience earlier diagnosis, lower stage at presentation, fewer ED visits, and improved long-term continuity. Quality outcomes follow naturally from delivering and documenting the care the clinical picture demands — they are **consequences of good care**, not separate goals.

DOCUMENTATION

When a treatment decision is reached at a multidisciplinary tumor board, document the recommendation, the clinical reasoning (NMIBC risk stratum vs MIBC stage, cisplatin eligibility per eGFR, G8/CGA findings, biomarker status), the patient's expressed preferences, and the agreed plan. Anchor surveillance documentation to the active C67.x code through BCG maintenance and surveillance — Z85.51 applies only after complete eradication and end of active surveillance.

AAVBC PERSPECTIVE

*Both **anticholinergic medications** and **beta-3 agonists** suppress urgency and frequency, the same symptoms produced by **carcinoma in situ** and bladder tumors. Symptomatic improvement on any OAB agent does not exclude **underlying malignancy**, and initiating pharmacotherapy without first considering cystoscopy in any patient **≥60 with risk factors** carries the same diagnostic risk as the delay it creates downstream. The same principle applies once cancer is confirmed: **BCG maintenance** is an active, ongoing treatment requiring repeated instillations over one to three years, cognitive capacity for adherence, and active primary care monitoring.*

*AAVBC supports a primary care approach to bladder cancer management that prioritizes **early detection**, **accurate documentation**, and proactive coordination of ongoing treatment,*

recognizing that diagnostic delay, symptom misattribution, and incomplete therapy represents the most consequential and preventable failures in this population.

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

ELEMENT	DOCUMENTATION REQUIREMENT
Anatomic subsite (C67.0–C67.8)	**Document specific subsite** (trigone, dome, lateral wall, anterior wall, posterior wall, bladder neck, ureteric orifice, urachus, overlapping)[7] from cystoscopy/TURBT report. Avoid C67.9 (unspecified) when subsite is available
Tumor histology and grade	**Confirm urothelial carcinoma vs squamous cell carcinoma vs adenocarcinoma**; document **grade** (low-grade vs high-grade) and **T stage** (Tis, Ta, T1, T2, T3, T4)
Active vs personal history	**Use C67.x while disease is active OR under surveillance**/BCG maintenance/known residual tumor. Z85.51 (personal history) applies **ONLY** after **complete eradication AND end of active surveillance** — most consequential coding error in bladder cancer
CIS vs invasive disease	**D09.0 (CIS) does NOT map to HCC 22**. CIS is a flat, high-grade lesion documented by pathology; update to C67.x if progression to invasive disease confirmed
Metastatic site coding	C79.11 (secondary malignant neoplasm OF bladder from a known primary site) maps to HCC 18; **document both primary tumor site and bladder involvement**
NMIBC risk stratum	**Document AUA/SUO risk stratum** (low, intermediate, high, very-high) to drive surveillance and treatment intensity
Performance and frailty status	**Document ECOG and G8** (if obtained), with CGA findings when triggered
Biomarker status (metastatic/cisplatin-ineligible MIBC)	**Document NGS tumor results**: FGFR alterations (erdafitinib eligibility), MSI/dMMR and TMB-H (pembrolizumab continuation), HER2 (T-DXd)[8]
Associated comorbidities	**Code CKD stage** (cisplatin eligibility), cognitive impairment (BCG maintenance feasibility), tobacco use (F17.x — continuing risk-modifier), anticholinergic burden, depression (F32.x) when documented

ELEMENT	DOCUMENTATION REQUIREMENT

ABBREVIATIONS: AUA/SUO = AUA/Society of Urologic Oncology; BCG = Bacillus Calmette-Guérin; CGA = comprehensive geriatric assessment; CIS = carcinoma in situ; CKD = chronic kidney disease; dMMR = mismatch repair deficient; ECOG = Eastern Cooperative Oncology Group; FGFR = fibroblast growth factor receptor; G8 = Geriatric 8; HCC = Hierarchical Condition Category; HER2 = human epidermal growth factor receptor 2; MIBC = muscle-invasive bladder cancer; MSI = microsatellite instability; NGS = next-generation sequencing; NMIBC = non-muscle-invasive bladder cancer; T-DXd = fam-trastuzumab deruxtecan-nxki; TMB-H = tumor mutational burden high; TURBT = transurethral resection of bladder tumor

Annual Clinical Review and Confirmation

- **Annual review:** Active bladder cancer (**C67.x**) must be reassessed annually with **MEAT documented**; patients on active surveillance, BCG maintenance, or with known residual disease remain **C67.x** — **Z85.51** (personal history) applies only after complete eradication and end of active surveillance
- **Visit modality:** Face-to-face or synchronous audio-video telehealth qualifies when it supports **meaningful clinical evaluation**; chart updates without an encounter do not satisfy MEAT
- **Clinical context:** Under **CMS-HCC V28**, active bladder malignancy maps to **HCC 22** (CNA RAF 0.363 ≈ $3,776/year illustrative); secondary malignancy of bladder from elsewhere (**C79.11**) maps to **HCC 18** (RAF 2.341)[7]
- **Avoid rollover:** Do not copy forward last year's bladder cancer note without updating **treatment status**, current line of therapy and cycle, surveillance interval, **AUA/SUO risk stratum**, biomarker results, and active comorbidities — silent rollover misrepresents the care being delivered

Good Documentation is Comprehensive Coding

EHR SHORTCUT/RISK	PREFERRED DOCUMENTATION LANGUAGE
Defaulting to C67.9 (unspecified) when cystoscopy or pathology specifies subsite	'High-grade T1 urothelial carcinoma of the left lateral wall (C67.2), confirmed by TURBT [date]' — review specialist documentation for subsite
Using Z85.51 (personal history) for a patient on active surveillance, BCG maintenance, or with known residual tumor	Use C67.x while disease is active or under surveillance. 'Active urothelial carcinoma on BCG maintenance (instillation 4 of 12) — C67.2'. Z85.51 only after complete eradication and end of active surveillance
Treating CIS (D09.0) as equivalent to active invasive cancer for HCC purposes	'Carcinoma in situ of bladder, confirmed by TURBT pathology [date] — D09.0 (NOT mapped to HCC 22); close cystoscopy surveillance; update to C67.x if progression'

EHR SHORTCUT/RISK	PREFERRED DOCUMENTATION LANGUAGE
'Bladder cancer, on BCG'	'High-grade T1 urothelial carcinoma of the lateral wall (C67.2), BCG induction (instillation 4 of 6); tolerating with grade 1 dysuria, no fever, no BCG sepsis signs'
'Hematuria, possibly UTI'	'Microscopic hematuria 18 RBC/HPF in patient ≥60 with 35 pack-years (AUA/SUFU high-risk stratum); cystoscopy + CT urogram ordered'
'OAB'	'New-onset overactive bladder symptoms in patient ≥60 with smoking history; cystoscopy completed prior to OAB therapy to exclude underlying tumor; β3 agonist (mirabegron) initiated rather than anticholinergic given dementia-risk profile'

ABBREVIATIONS: AUA = American Urological Association; BCG = Bacillus Calmette-Guérin; CIS = carcinoma in situ; CT = computed tomography; HCC = Hierarchical Condition Category; HPF = high-power field; OAB = overactive bladder; RBC = red blood cell; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; TURBT = transurethral resection of bladder tumor; UTI = urinary tract infection

EHR Workflow Tips

TAG	TIP
SMARTPHRASE	Build a **'.bladdercancer'** or **'.bca'** dot phrase that documents anatomic subsite, AUA/SUO risk stratum or stage, current treatment (BCG induction/maintenance, surveillance interval), ECOG/G8, smoking status, and active comorbidities (CKD stage, cognitive screen, anticholinergic burden)
FILTER	**Worklist filter for active C67.x with no urology visit in last 6 months** — surface patients who may have lapsed surveillance; secondary filter for active C67.x without documented tobacco-cessation counseling in current year
PROBLEM LIST	**Maintain active C67.x with specific subsite and current NMIBC risk stratum or MIBC stage**; mark D09.0 (CIS) separately from invasive C67.x; never use Z85.51 while patient is under active surveillance or BCG maintenance
ANNUAL DX	**Year-end workflow flag** for any active C67.x without face-to-face or synchronous audio-video encounter and MEAT documentation in past 12 months
ORDER SET	**Hematuria workup bundle**: UA with microscopy, urine cytology, AUA/SUFU risk stratification → cystoscopy ± CT urogram ± renal ultrasonography per stratum; new-diagnosis bundle adds urology referral, tobacco-cessation referral, multidisciplinary clinic referral
REFERRAL	**Triggered referrals:** gross hematuria → urology within 24–48 hours; AUA/SUFU high-risk → urology + CT urogram order; confirmed bladder cancer → multidisciplinary clinic, geriatric oncology if G8 ≤14, tobacco cessation

TAG	TIP

ABBREVIATIONS: AUA = American Urological Association; AUA/SUO = AUA/Society of Urologic Oncology; BCG = Bacillus Calmette-Guérin; CIS = carcinoma in situ; CKD = chronic kidney disease; CT = computed tomography; ECOG = Eastern Cooperative Oncology Group; G8 = Geriatric 8; HCC = Hierarchical Condition Category; MEAT = monitor/evaluate/assess/treat; MIBC = muscle-invasive bladder cancer; NMIBC = non-muscle-invasive bladder cancer; SUFU = Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction; UA = urinalysis

Brief Case Examples

✓ SUCCESS — COMPREHENSIVE DOCUMENTATION

Patient: 72-year-old woman, 35 pack-year former smoker, presents with two episodes of gross hematuria over 6 weeks, attributed initially to recurrent UTI (negative cultures × 2). Primary care recognized the diagnostic-delay pattern in women, ran a urinalysis (12 RBC/HPF), ordered urine cytology, and made an urgent urology referral within 48 hours — not another empirical antibiotic course

Documentation: 'High-grade Ta urothelial carcinoma of the trigone (C67.0), confirmed by TURBT 4/22; AUA/SUO intermediate-risk NMIBC; BCG induction (6 weekly) initiated 5/14, with planned 1-year SWOG maintenance. Former smoker 35 pack-years (F17.211) — tobacco cessation counseling continued. ECOG 1; G8 13 → CGA placed. Patient previously on oxybutynin for OAB — switched to mirabegron 25 mg daily given anticholinergic-burden concern. CKD stage 2 (eGFR 64 mL/min — cisplatin-eligible if progression to MIBC). Surveillance cystoscopy at 3 months scheduled.'

Outcome: HCC 22 (active malignancy) documented with anatomic specificity (C67.0)[7]; risk-stratified treatment plan documented; anticholinergic switch reflects evidence-based comorbidity management;[19] CGA placement supports geriatric-tailored care. CA continuity through surveillance with primary care anchoring tobacco-cessation and CKD monitoring

⚠ PITFALL — INSUFFICIENT DOCUMENTATION

Documentation as written: 'History of bladder cancer; on BCG.' Coded as Z85.51. Patient is in month 4 of a 3-year SWOG-protocol BCG maintenance regimen for high-risk T1 disease. Smoking status, anticholinergic exposure, and CKD stage are not documented in the active problem list. The chart references 'OAB on oxybutynin' as a separate problem with no review for protopathic bias or dementia-risk anticholinergic burden.

Consequence: Z85.51 does NOT map to any HCC; using it during active BCG maintenance fails to document HCC 22 (RAF 0.363) and understates clinical complexity by the full RAF. Anticholinergic burden in a patient ≥60 carries independent dementia risk (OR 1.49) and may mask undiagnosed disease (protopathic bias); not documenting this misses both quality-improvement opportunity and continuity

RAF Impact: Lost HCC 22 documentation (CNA RAF 0.363 ≈ $3,776/year illustrative) for the full duration of active BCG maintenance and surveillance; missed comorbidity coding (CKD stage, tobacco use) further understates clinical complexity

Fix: Update problem list and assessment: 'Active high-grade T1 urothelial carcinoma of the lateral wall (C67.2), on BCG maintenance month 4 of 36 per SWOG protocol; CKD stage 2 (N18.2); current tobacco use (F17.210) — cessation counseling continued; OAB switched from oxybutynin to mirabegron given anticholinergic-burden/dementia-risk profile (N32.81).' Document MEAT for each at the next encounter; reserve Z85.51 for the period after complete eradication AND end of active surveillance

REFERENCES

1. American Cancer Society. Key statistics for bladder cancer. American Cancer Society. https://www.cancer.org/cancer/types/bladder-cancer/about/key-statistics.html. Accessed June 2, 2026.
2. Mayo Clinic. Bladder cancer — symptoms and causes. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/bladder-cancer/symptoms-causes/syc-20356104. Accessed June 2, 2026.
3. Isharwal S, Konety B. Non-muscle invasive bladder cancer risk stratification. *Indian J Urol.* 2015;31(4):289–296. doi:10.4103/0970-1591.166445
4. Centers for Medicare & Medicaid Services; National Center for Health Statistics. C67 — Malignant neoplasm of bladder. Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Coding/ICD10. Accessed May 21, 2026.
5. DeGeorge KC, Holt HR, Hodges SC. Bladder cancer: diagnosis and treatment. *Am Fam Physician.* 2017;96(8):507–514.
6. Lin W, Pan X, Zhang C, Ye B, Song J. Impact of age at diagnosis of bladder cancer on survival: a Surveillance, Epidemiology, and End Results-based study 2004–2015. *Cancer Control.* 2023;:10732748231152322. doi:10.1177/10732748231152322
7. Richards KA, Ham S, Cohn JA, Steinberg GD. Urinary tract infection-like symptom is associated with worse bladder cancer outcomes in the Medicare population. *Int J Urol.* 2016;23(1):42–47. doi:10.1111/iju.12959
8. National Comprehensive Cancer Network. Bladder Cancer. Version 1.2026. Updated March 16, 2026. https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1417. Accessed June 2, 2026.
9. Barocas DA, Lotan Y, Matulewicz RS, et al. Updates to microhematuria: AUA/SUFU guideline (2025). *J Urol.*2025;213(5):547–557. doi:10.1097/JU.0000000000004490
10. Moyer VA; U.S. Preventive Services Task Force. Screening for bladder cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med.* 2011;155(4):246–251. doi:10.7326/0003-4819-155-4-201108160-00008
11. Al-Zalabani AH, Stewart KF, Wesselius A, Schols AM, Zeegers MP. Modifiable risk factors for the prevention of bladder cancer: a systematic review of meta-analyses. *Eur J Epidemiol.* 2016;31(9):811–851. doi:10.1007/s10654-016-0138-6
12. Leslie SW, Soon-Sutton TL, Aeddula NR. Bladder Cancer. In: *StatPearls* [Internet]. StatPearls Publishing; 2026 Jan. Updated August 15, 2024. https://www.ncbi.nlm.nih.gov/books/NBK536923/
13. Lenis AT, Lec PM, Chamie K, Mshs MD. Bladder cancer: a review. *JAMA.* 2020;324(19):1980–1991. doi:10.1001/jama.2020.17598
14. Tachibana M, Tsubouchi K, Fukuhara Y, et al. Factors related to overactive bladder-like symptoms in bladder cancer. *Anticancer Res.* 2023;43(8):3607–3613. doi:10.21873/anticanres.16540
15. Cohn JA, Vekhter B, Lyttle C, Steinberg GD, Large MC. Sex disparities in diagnosis of bladder cancer after initial presentation with hematuria. *Cancer.* 2014;120(4):555–561. doi:10.1002/cncr.28416

16. Zillioux J, Welk B, Suskind AM, Gormley EA, Goldman HB. SUFU white paper on overactive bladder anticholinergic medications and dementia risk. *Neurourol Urodyn.* 2022;41(8):1928–1933. doi: 10.1002/nau.25037

17. Coupland CAC, Hill T, Dening T, et al. Anticholinergic drug exposure and the risk of dementia: a nested case-control study. *JAMA Intern Med.* 2019;179(8):1084–1093. doi:10.1001/jamainternmed. 2019.0677

18. Zhang D, Ren J, Ye J, et al. Bladder cancer risk factors: a comprehensive umbrella review of meta-analyses. *Int J Surg.* 2025. doi:10.1097/JS9.0000000000003371

19. Li H, Zeng S, Yang C, et al. Global, regional, and national burden and trends of bladder cancer in individuals aged 55 years and older from 1990 to 2021: findings from the Global Burden of Disease Study 2021. *Int J Surg.* 2025. doi:10.1097/JS9.0000000000003254

20. Myers AA, Duan Z, Igel DA, et al. Disparities and temporal trends in referral for bladder cancer diagnosis: A worsening epidemic. *Urol Oncol*. 2026;44(2):120.e1-120.e. doi:10.1016/j.urolonc. 2025.11.012

21. Din NU, Ukoumunne OC, Rubin G, et al. Age and gender variations in cancer diagnostic intervals in 15 cancers: analysis of data from the UK Clinical Practice Research Datalink. *PLoS One.* 2015;10(5):e0127717. doi:10.1371/journal.pone.0127717

22. Myers AA, Duan Z, Igel DA, et al. Disparities and temporal trends in referral for bladder cancer diagnosis: a worsening epidemic. *Urol Oncol.* 2025;S1078-1439(25)00477-6. doi:10.1016/j.urolonc. 2025.11.012

23. Hasan S, Lazarev S, Garg M, et al. Racial inequity and other social disparities in the diagnosis and management of bladder cancer. *Cancer Med.* 2023;12(1):640–650. doi:10.1002/cam4.4917

24. Nielsen M, Qaseem A; High Value Care Task Force of the American College of Physicians. Hematuria as a marker of occult urinary tract cancer: advice for high-value care from the American College of Physicians. *Ann Intern Med.*2016;164(7):488–497. doi:10.7326/M15-1496

25. Holzbeierlein JM, Bixler BR, Buckley DI, et al. Diagnosis and treatment of non-muscle invasive bladder cancer: AUA/SUO guideline — 2024 amendment. *J Urol.* 2024;211(4):533–538. doi:10.1097/JU. 0000000000003846

26. Bimbatti D, Cavasin N, Bergo E, et al. Role of geriatric assessment and Oncological Multidimensional Prognostic Index (Onco-MPI) in a real-world cohort of elderly patients with advanced urothelial carcinoma. *J Clin Oncol.*2024;42(suppl 4):563. doi:10.1200/JCO.2024.42.4_suppl.563

27. Mottet N, Ribal MJ, Boyle H, et al. Management of bladder cancer in older patients: position paper of a SIOG task force. *J Geriatr Oncol.* 2020;11(7):1043–1053. doi:10.1016/j.jgo.2020.02.001

28. Lozano-Ortega G, Walker DR, Johnston K, et al. Comparative safety and efficacy of treatments for overactive bladder among older adults: a network meta-analysis. *Drugs Aging.* 2020;37(11):801–816. doi:10.1007/s40266-020-00792-9

29. Kovoor JG, Jacobsen JHW, Stretton B, et al. Depression after stoma surgery: a systematic review and meta-analysis. *BMC Psychiatry.* 2023;23(1):352. doi:10.1186/s12888-023-04871-0

30. GoodRx. Drug pricing: oxybutynin chloride extended-release; oxybutynin immediate-release; tolterodine tartrate extended-release. GoodRx. https://www.goodrx.com. Accessed June 2, 2026.

31. SingleCare. Drug pricing: mirabegron ER (Myrbetriq); Tice BCG. SingleCare. https:// www.singlecare.com. Accessed June 2, 2026.

32. Sumitomo Pharma America Inc. GEMTESA (vibegron) 75 mg tablets: savings and pricing. GEMTESA. https://www.gemtesa.com/savings-and-pricing/. Updated August 2024. Accessed June 2, 2026.

33. Drugs.com. TheraCys (BCG live) price guide; Padcev (enfortumab vedotin-ejfv) price guide. Drugs.com. https://www.drugs.com. Accessed June 2, 2026.

34. AIS Health. FDA approves game-changing regimen for urothelial cancer, but will cost pose issue? Prime Therapeutics. https://www.primetherapeutics.com/w/fda-approves-game-changing-regimen-for-urothelial-cancer-but-will-cost-pose-issue-. Published December 2023. Accessed June 2, 2026.

35. Centers for Medicare & Medicaid Services. 2026 MIPS Quality Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. Quality Payment Program. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2025_Measure_226_MIPSCQM.pdf. Accessed June 2, 2026.

36. Centers for Medicare & Medicaid Services. 2026 Star Ratings Measures and Weights. https://www.cms.gov/files/document/2026-star-ratings-measures.pdf. Accessed June 2, 2026.

37. Centers for Medicare & Medicaid Services. 2026 MIPS Quality Measure #47: Advance Care Plan (NQF #0326). Quality Payment Program. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2025_Measure_047_MIPSCQM.pdf. Accessed June 2, 2026.

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