National Committee for Quality Assurance (NCQA)
Physician Consortium for Performance Improvement® (PCPI)
American College of Rheumatology (ACR)

Rheumatoid Arthritis

Physician Performance Measurement Set

PCPI Approved
July 2008

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Rheumatoid Arthritis

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Purpose of Measures:

These clinical performance measures, developed by the American College of Rheumatology, the National Committee for Quality Assurance (NCQA), and the Physician Consortium for Performance Improvement® (PCPI), are designed for individual quality improvement. The measures may also be used in data registries, continuing medical education programs, and in board certification programs. Unless otherwise indicated, the measures are appropriate for accountability if appropriate methodological, statistical, and implementation rules are achieved.

The measure titles listed below may be used for accountability:

Measure #1: Tuberculosis Screening
Measure #2: Periodic Assessment of Disease Activity
Measure #3: Functional Status Assessment
Measure #4: Assessment and Classification of Disease Prognosis
Measure #5: Glucocorticoid Management

Intended Audience, Care Setting, and Patient Population:

These measures are designed for use by physicians and eligible health professionals where appropriate, and for calculating reporting or performance measurement at the individual clinician level.

Measures 1 through 5 are designed for any clinician managing ongoing care for patients aged 18 years and older with a diagnosis of rheumatoid arthritis.

Importance of Topic:

Incidence, Prevalence, & Cost

Rheumatoid Arthritis (RA) is a multisystem disorder of unknown etiology, characterized by chronic destructive synovitis. The current national estimate of prevalence of RA, using 2005 population estimates from the Census Bureau, is that 1,293,000 American adults age ≥ 18 years (0.6%) have RA. This estimate is lower than prior estimates due to stricter disease classification criteria. The prevalence in women is approximately double that in men (1.06% vs. 0.61%), and the average age of persons with prevalent RA has increased steadily over time, from 63.3 years in 1965 to 66.8 years in 1995, suggesting that RA is becoming a disease of older adults.[1]

Nationwide incidence rates for RA do not exist; however, data from several local studies offer an estimation of incidence rates. A study conducted in Rochester, Minnesota indicate that the incidence rate of RA decreased between 1955 and 1994 – from 61.2/100,000 in 1955-1964, to 32.7/100,000 in 1985-1994 (based on an adult, white population).[2] Data taken from a group health cooperative in Seattle, Washington from 1987-1989 indicated an incidence rate among women that was 44.7% lower than the rate reported in the Rochester study.[3] Another study using data from a health maintenance organization in Massachusetts estimated an incidence rate of 22/100,000 for men and 60/100,000 for women.[4] The differences in incidence rates may be due to the various methodologies and diagnostic classifications used by each of the studies, as well as new diagnostic criteria established in 1987.

The costs of RA are increasing because of the introduction and increasing use of biologic therapy. The mean total annual direct medical care cost in 2001 for a patient with RA was $9,519. Drug costs were $6,324 (66% of the total), while hospitalization costs were only $1,573 (17%). Approximately 25% of patients received biologic therapy. The mean total annual direct cost for patients receiving biologic agents was $19,016 per year, while the costs for those not receiving biologic therapy was $6,164. The remaining 16% of total costs includes outpatient services such as outpatient surgery, physician and health professional encounters, x-rays, MRI and CT scans and other laboratory testing. Medicare patients incur a high rate of out-of-pocket drug costs; 46% of Medicare patients paid greater than 25% of their drug expenses. The key clinical factors in predicting future costs are functional disability and comorbidity.[5]

Disparities

There is a paucity of literature investigating disparities in the prevalence and treatment of RA. However, one literature review found that females are twice as likely to develop rheumatoid arthritis as males. Native Americans

have the highest rates of disease incidence and greater severity while Asians and Africans have the lowest rate of incidence and less severity.[6]

Opportunity for Improvement/Gap or Variation in Care

While there are a limited number of studies that investigate gaps in care for patients with rheumatoid arthritis, the research that does exist identifies opportunities for improvement in several care areas: 1) there is a lack of adherence to RA guidelines, most noticeably in the use of disease-modifying antirheumatic drugs, and 2) variations in care by practice setting, geographic region and physician specialty.

One study analyzed quality of care for 1,355 patients with rheumatoid arthritis using data from a national health plan. Using process measures, the study found that patients with rheumatoid arthritis often did not receive the recommended care suggested by clinical guidelines (for each person-year, recommended processes of care for rheumatoid arthritis were performed an average 62% of the time). The study also found that the quality of care provided to patients with RA varied according to provider type (patients seeing a rheumatologist had higher quality care than those seeing a primary care physician).[7] Similar results were reported by a cohort study of 1,025 patients with RA. Based on certain outcome measures (including pain rating, number of painful joints, and functional status), patients with a rheumatologist as their RA physician had significantly better outcomes than patients whose main RA physician was a non-rheumatologist.[8]

Before publishing an endorsed quality indicator set in 2006, the American College of Rheumatology assessed rates for the quality indicators in a population of 568 patients with RA. While rates were high for certain quality indicators (98% of patients received at least one joint examination), the rates for other indicators were substantially lower. Seventy four percent of patients received a physician global assessment and 79% received a patient global assessment. Treatment rates were also not optimal – 85% of patients received a disease modifying antirheumatic drug (DMARD). Despite guideline recommendations that suggest a patient should receive some adjustment in treatment after six months of maintained or increased disease activity, only 50% of patients in the study received a DMARD adjustment after at least one documented increase in disease activity. For patients who had a documented increase in disease activity twice within one year, 64% received a DMARD adjustment.[9] In another study of 377 patients with RA, 50% of patients with persistent disease activity received a change in DMARD medication or dose within six months of meeting criteria for severe disease activity (the rate was 23% for those meeting criteria for moderate disease activity). Within one year of meeting criteria for severe disease activity, 68% of patients had received a change in DMARD medication or dose (the rate was 34% for those meeting criteria for moderate disease activity).[10]

Available Evidence

Evidenced-based clinical practice guidelines are available for the management of RA. This measurement set is based on clinical recommendations and guidelines from the following:

- American College of Rheumatology
- British Society for Rheumatology

The performance measures found in this document have been developed to be consistent with these recommendations and guidelines, enabling the clinician to track his or her performance in individual patient care across patient populations. *Please note that treatment must be based on individual patient needs and professional judgment.*

Measure Harmonization:

There is not an existing set of RA measures, but when there were similar measures in other disease areas, NCQA and the PCPI attempted to harmonize the measures to the extent feasible.

Measure Testing & Implementation:

Measure Testing & Implementation

Measures in the Rheumatoid Arthritis measurement set have not yet been tested or implemented. Upon approval from CMS, they will be considered for the Physician Quality Reporting Initiative in 2009. They will also be pilot tested with physicians in 2008.

Measure Endorsement/Selection

The measures were selected by the AQA in August 2008.

Measure Specifications:

NCQA and the PCPI seek to specify measures for implementation using multiple data sources, including paper medical record, administrative (claims) data, and particular emphasis on Electronic Health Record Systems (EHRS). Specifications to report on these measures for Rheumatoid Arthritis using administrative (claims) data are included in this document. We have identified codes for these measures, including ICD-9 and CPT (Evaluation & Management Codes, Category I and where Category II codes would apply). Specifications for additional data sources, including EHRS, will be fully developed at a later date.

Measure Exclusions:

For ***process measures***, NCQA and the PCPI provide three categories of reasons for which a patient may be excluded from the denominator of an individual measure:

- **Medical reasons**
  Includes:
  - not indicated (absence of organ/limb, already received/performed, other)
  - contraindicated (patient allergic history, potential adverse drug interaction, other)

- **Patient reasons**
  Includes:
  - patient declined
  - economic, social, or religious reasons
  - other patient reasons

- **System reasons**
  Includes:
  - resources to perform the services not available
  - insurance coverage/payor-related limitations
  - other reasons attributable to health care delivery system

These measure exclusion categories are not available uniformly across all measures; for each measure, there must be a clear rationale to permit an exclusion for a medical, patient, or system reason. The exclusion of a patient may be reported by appending the appropriate modifier to the CPT Category II code designated for the measure:

- **Medical reasons**: modifier 1P
- **Patient reasons**: modifier 2P
- **System reasons**: modifier 3P

Although this methodology does not require the external reporting of more detailed exclusion data, NCQA and the PCPI recommend that physicians document the *specific* reasons for exclusion in patients' medical records for purposes of optimal patient management and audit-readiness. NCQA and the PCPI also advocate the systematic review and analysis of each physician's exclusions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exclusion.

Please refer to documentation for each individual measure for information on the acceptable exclusion categories and the codes and modifiers to be used for reporting.

Measures #1-5 in the Rheumatoid Arthritis measurement set are process measures.

For ***outcome measures***, the PCPI specifically identifies all acceptable reasons for which a patient may be excluded from the denominator. Each specified reason is reportable with a CPT Category II code designated for that purpose.

There are no outcome measures in the Rheumatoid Arthritis measurement set.

References

[1] Helmick CG, Felson DT, Lawrence RC, Gabriel S, Hirsch R, Kwoh CK, et al. Estimates of the prevalence of arthritis and other rheumatic conditions in the United States. *Arth Rheum*. 2008; 58(1): 15-25.
[2] Doran MF, Pond GR, Crowson CS, O'Fallon WM, Gabriel SE. Trends in incidence and mortality in rheumatoid arthritis in Rochester, Minnesota, over a forty-year period. *Arth Rheum*. 2002; 46(3): 625-631.
[3] Dugowson CE, Koepsell TD, Voigt LF, Bley L, Nelson JL, Daling JR. Rheumatoid arthritis in women. Incidence rates in group health cooperative, Seattle, Washington, 1987-1989. *Arth Rheum*. 1991; 34(12): 1502-1507.
[4] Kin-Wei AC, Felson DT, Yood RA, Walker AM. Incidence of rheumatoid arthritis in central Massachusetts. *Arth Rheum*. 2005; 36(12): 1691-1696.
[5] Michaud K, Messer J, Choi HK, Wolfe F. Direct medical costs and their predictors in patients with rheumatoid arthritis. *Arth Rheum*. 2003; 48(10): 2750-2762.
[6] Groessl EJ, Ganiats TG, Sarkin AJ. Sociodemographic Differences in Quality of Life in Rheumatoid Arthritis. *Pharmacoeconomics* 2006; 24 (2): 109-121
[7] MacLean CH, Louie R, Leake B, et al. Quality of care for patients with rheumatoid arthritis. *JAMA*. 2000; 284:984–992.
[8] Yelin E, Such C, Criswell L, et al. Outcomes for persons with rheumatoid arthritis with a rheumatologist versus nonrheumatologist as the main physician for this condition. *Med Care*. 1998; 36:513–522.
[9] Kahn KL, Maclean CH, Wong AL, et al. Assessment of American College of Rheumatology quality criteria for rheumatoid arthritis in a prequality criteria patient cohort. *Arthritis Rheum*. 2007; 57:707–715.
[10] Kahn KL, MacLean CH, Liu H, et al. Application of explicit process of care measurement to rheumatoid arthritis: moving from evidence to practice. *Arthritis Rheum.* 2006; 55:884–891.

Rheumatoid Arthritis

Measure #1: Tuberculosis Screening

Measure Description

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying antirheumatic drug (DMARD).

Measure Detail

Numerator	Patients for whom a TB screening was performed and results interpreted within six months prior to receiving a first course* of therapy using a biologic DMARD * First Course of Therapy: only patients who have previously never been prescribed or dispensed biologic DMARD therapy should be included in this measure.
Denominator	Patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) and receiving a first course of therapy using a biologic disease-modifying antirheumatic drug (DMARD)
Denominator Exclusions	Documentation of medical reason for not screening for TB (i.e. patient positive for TB and documentation of past treatment; patient who has recently completed a course of anti-TB therapy)
Supporting Guideline	The following evidence statements are quoted verbatim from the referenced clinical guidelines. The task force panel (TFP) recommended routine tuberculosis screening to identify latent TB infection in patients being considered for therapy with biologic agents. The evidence for TB testing is based on a documented higher incidence of TB following anti-TNFα therapy. To begin, the TFP recommended that clinicians should ask all RA patients being considered for biologic DMARD therapy about their potential risk factors for TB infection and, irrespective of prior Bacillus Calmette-Guérin (BCG) vaccination, should use a TB skin test (TST) as a diagnostic aid to assess the patient's probability of latent TB infection. (ACR, 2008)[1] Prior to commencing treatment with anti-TNF, all patients should be screened for TB in accordance with the British Thoracic Society (BTS) guidelines. Active TB needs to be adequately treated before anti-TNF therapy can be started. Prior to commencing anti-TNF therapy, consideration of prophylactic anti-TB therapy (as directed by the BTS guidelines) should be given to patients with evidence of potential latent disease (past history of TB treatment or abnormal chest X-ray raising the possibility of TB) after consultation with a local TB specialist. All patients commenced on anti-TNF therapies need to be closely monitored for TB. (Level of Evidence C) (British Society for Rheumatology, 2005)[2]

Measure Importance

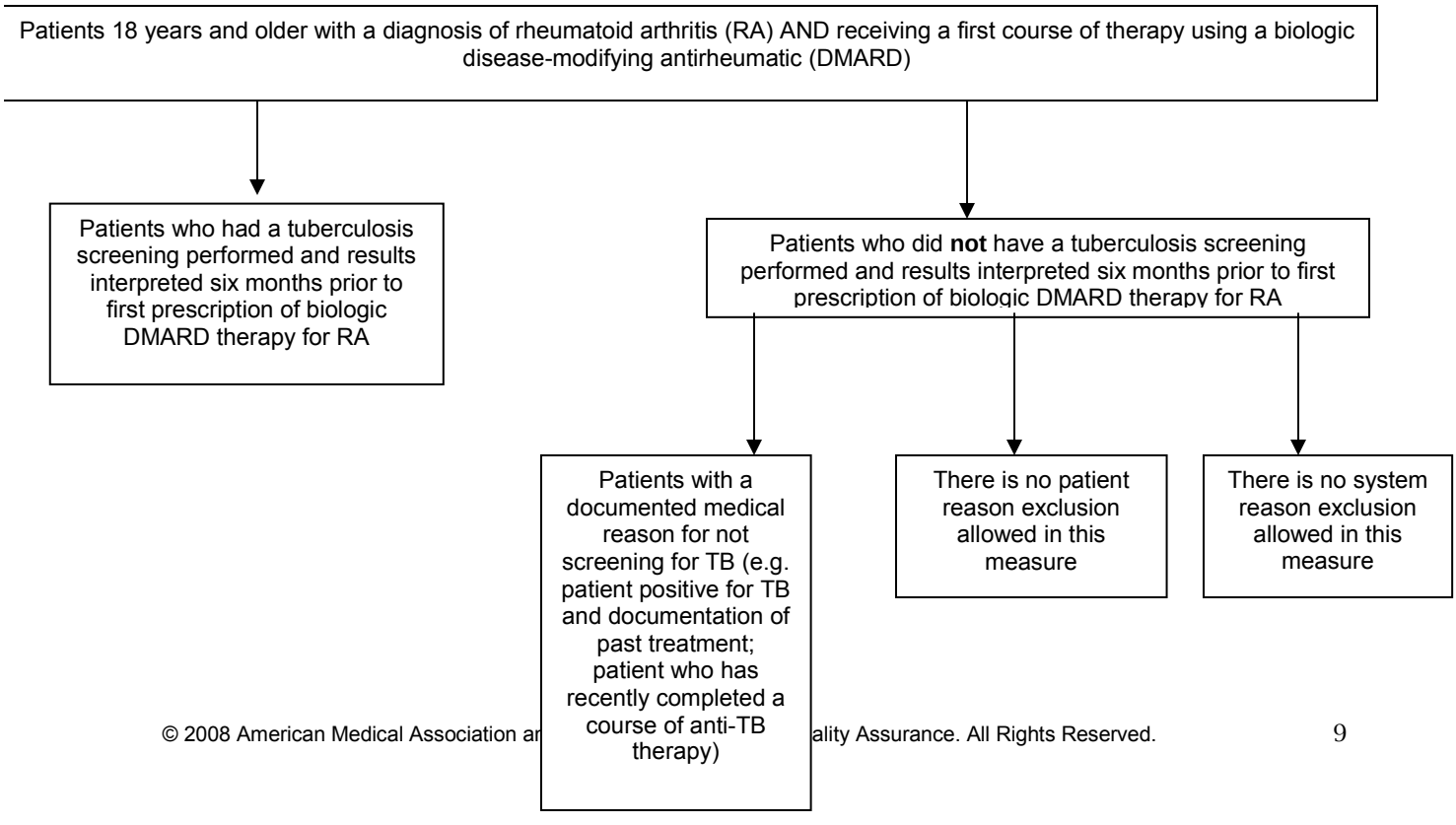
Relationship to desired outcome	Before initiating biologic DMARDs for a patient with RA, it is essential to screen the patient for tuberculosis, as research has documented a higher incidence of TB after anti-TNFα therapy. All patients being considered for biologic DMARD should receive a tuberculin skin test, even if the patient has previously received the BCG vaccination. Test results, in addition to patient risk for TB and other tests, should be used to assess the patient's risk for latent TB infection. This is a patient safety measure.
Opportunity for Improvement	While there are a limited number of studies that investigate gaps in care for patients with rheumatoid arthritis, the research that does exist identifies opportunities for improvement in several care areas: 1) there is a lack of adherence to RA guidelines, most noticeably in the use of disease-modifying antirheumatic drugs, and 2) variations in care by practice setting, geographic region and physician specialty. It is the belief of the RA Expert Workgroup that this area has potential for improvement; and more information about gaps in care will be discovered during the field-test of the measure.

	Variation and room for improvement will be demonstrated for this measure during pilot testing.
Exclusion Justification	The Expert Work Group recommended that the measure requires a medical reason exclusion for patients with existing TB or a prior positive TB skin test. Clinical guidelines support this exclusion: "Active TB needs to be adequately treated before anti-TNF therapy can be started. Prior to commencing anti-TNF therapy, consideration of prophylactic anti-TB therapy (as directed by the BTS guidelines) should be given to patients with evidence of potential latent disease (past history of TB treatment or abnormal chest X-ray raising the possibility of TB) after consultation with a local TB specialist. All patients commenced on anti-TNF therapies need to be closely monitored for TB.
Harmonization with Existing Measures	There are no existing measures for TB Screening in RA patients. However, this measure was constructed to be harmonized with the National Committee for Quality Assurance/ Physician Consortium for Performance Improvement®/Infectious Diseases Society of America/HIV Medicine Association / Health Resources and Services Administration Tuberculosis (TB) Screening Measure.

Measure Designation

Measure purpose	• Quality Improvement • Accountability
Type of measure	• Process
Care setting	• Ambulatory Care
Data source	• Administrative Claims • Medical record • Electronic Medical Record • Administrative Claims supplemented by Electronic Medical Record • Pharmacy claims • Registries • Prospective data collection flowsheet

Actionable Feedback



Technical Specifications: Administrative Data

Denominator (Eligible Population)	All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) and receiving a first course of therapy using a biologic disease-modifying antirheumatic (DMARD) CPT E/M Service Code: • 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99455, 99456 AND ICD-9 Code for RA: • 714.0, 714.1, 714.2, 714.81 AND CPT Category II code: • 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis Definitions: Biologic DMARD therapy: Adalimunab, Etanercept, Infliximab, Abatacept, Anakinra (Rituximab is excluded) First Course of Therapy: Only patients who have NEVER been prescribed or dispensed biologic DMARD therapy should be included in this measure
Numerator	Patients for whom a TB screening was performed and results interpreted within six months prior to receiving a first course of therapy using a biologic disease modifying anti-rheumatic drug therapy for RA CPT Category II code: • 3455F: TB screening performed and results interpreted within six months prior to initiation of first-time biologic disease modifying anti-rheumatic drug therapy for RA
Denominator Exclusions	Documentation of medical reason(s) for not performing TB screening or interpreting results within six months prior to receiving a first course of therapy using a biologic DMARD • Append modifier to CPT Category II code: 3455F-1P

Technical Specifications: Electronic Health Record System

Technical specifications for electronic health record systems are developed for all measures after they are approved.

Technical Specifications: Prospective Data Collection Flowsheet

Prospective data collection flowsheets are developed for measure sets after they are approved.

References

[1] Saag KG, Teng GG, Patkar NM, Anuntiyo J, Finney C, Curtis JR, et al. American College of Rheumatology 2008 Recommendations for the Use of Nonbiologic and Biologic Disease-Modifying Antirheumatic Drugs in Rheumatoid Arthritis. Arthritis Rheum 2008:59(6): 762---784.
[2] Ledingham J, Deighton C, on behalf of the British Society for Rheumatology Standards, Guidelines and Audit Working Group (SGAWG). Update on the British Society for Rheumatology guidelines for prescribing TNFα blockers in adults with rheumatoid arthritis (update of previous guidelines of April 2001). *Rheumatology*. 2005; 44: 157-163.

Rheumatoid Arthritis

Measure #2: Periodic Assessment of Disease Activity

Measure Description

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease activity at least once within 12 months.

Measure Detail

Numerator	Patients with disease activity assessed by a standardized descriptive or numeric scale or composite index and classified into one of the following categories*: low, moderate or high, at least once within 12 months *Assessment and Classification of Disease Activity: This measure is looking for a physician assessment of the level of disease activity. The scales/instruments listed are examples of how to define activity level and cut-off points can differ by scale. Standardized descriptive or numeric scales and/or composite indexes could include **but are not limited to**: Disease Activity Score in 28 joints (DAS28), Simplified Disease Activity Index (SDAI), Clinical Disease Activity Index (CDAI), Rheumatoid Arthritis Disease Activity Index (RADAI), Routine Assessment Patient Index Data (RAPID)
Denominator	Patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)
Denominator Exclusions	None
Supporting Guideline	The following evidence statements are quoted verbatim from the referenced clinical guidelines. Several indices to measure RA disease activity have been developed, each of which has advantages and disadvantages. Evidence-based guidelines require clear definitions of disease activity to make rational therapeutic choices, but it is not possible or appropriate to mandate use of a single disease activity score for the individual physician, and different studies have used different definitions. Therefore, the TFP was asked to consider a combined estimation of disease activity, which allowed reference to many past definitions. With [these instruments] as a guide, we rated RA disease activity in an ordinal manner as low, moderate, or high. (ACR, 2008)[1]

Measure Importance

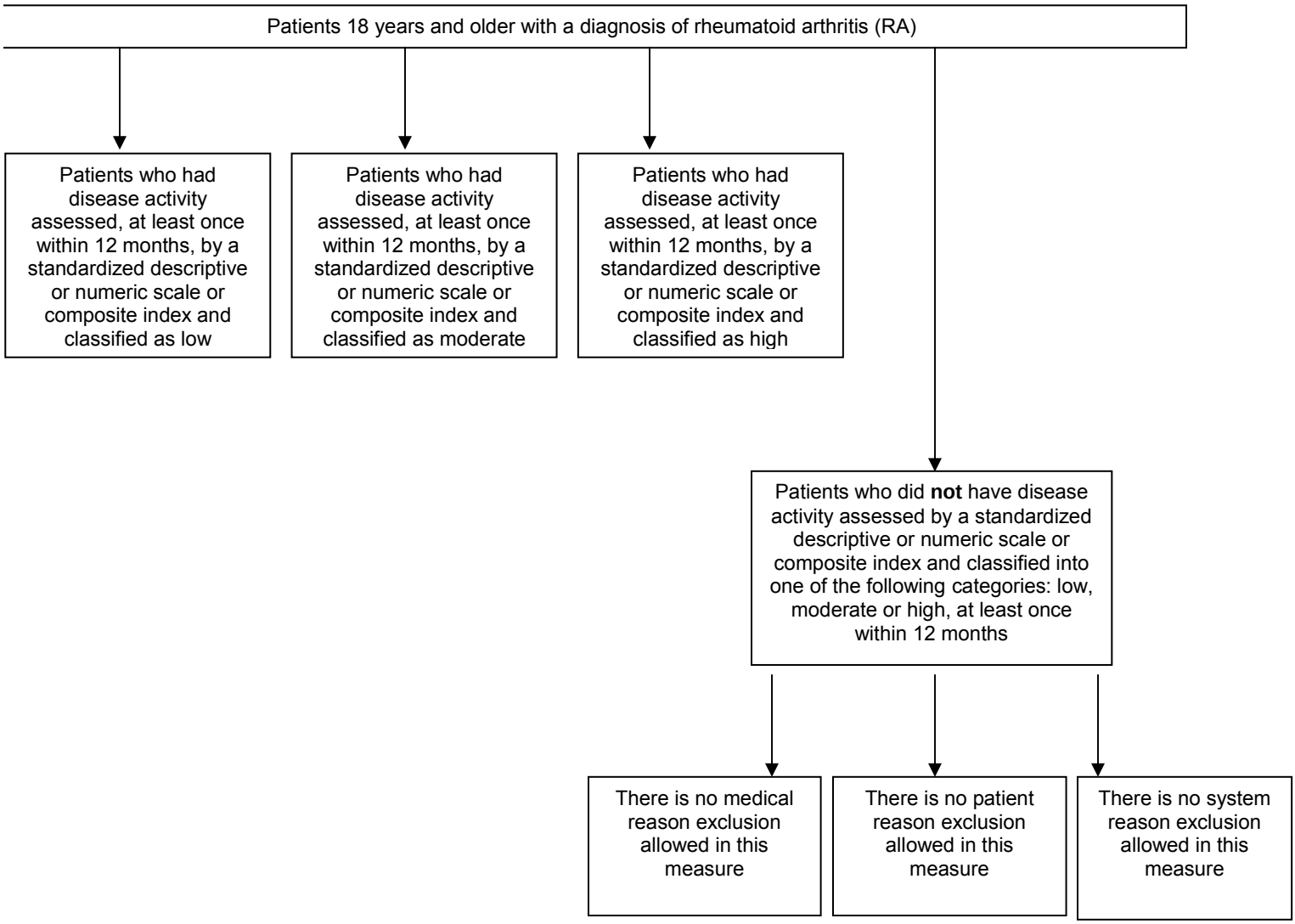
Relationship to desired outcome	After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the patient's disease activity at the time of the treatment decision.[1]
Opportunity for Improvement	While there are a limited number of studies that investigate gaps in care for patients with rheumatoid arthritis, the research that does exist identifies opportunities for improvement in several care areas: 1) there is a lack of adherence to RA guidelines, most noticeably in the use of disease-modifying antirheumatic drugs, and 2) variations in care by practice setting, geographic region and physician specialty. It is the belief of the RA Expert Work Group that this area has potential for improvement; and more information about gaps in care will be discovered during the field-test of the measure. Variation and room for improvement will be demonstrated for this measure during pilot testing.
Exclusion Justification	This measure has no exclusions.

Harmonization with Existing Measures	There are no existing measures for Disease Activity Assessment in RA patients.

Measure Designation

Measure purpose	• Quality Improvement • Accountability
Type of measure	• Process
Care setting	• Ambulatory Care
Data source	• Administrative claims • Medical record • Electronic Medical record • Administrative Claims supplemented by Medical Records • Prospective data collection flowsheet

Actionable Feedback



Technical Specifications: Administrative Data

Denominator (Eligible Population)	All patients 18 years and older with a diagnosis of Rheumatoid Arthritis (RA) CPT E/M Service Code: • 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99455, 99456 AND ICD-9 Code for RA: • 714.0, 714.1, 714.2, 714.81
Numerator	Patients with disease activity assessed by a standardized descriptive or numeric scale or composite index and classified into one of the following categories: low, moderate or high, at least once within 12 months CPT Category II code: • 3470F: RA disease activity, low OR • 3471F: RA disease activity, moderate OR • 3472F: RA disease activity, high Definition: Assessment and Classification of Disease Activity: This measure is looking for a physician assessment of the level of disease activity. The scales/instruments listed are examples of how to define activity level and cut-off points can differ by scale. Standardized descriptive or numeric scales and/or composite indexes could include **but are not limited to**: DAS28, SDAI, CDAI, RADAI, RAPID
Denominator Exclusions	None

Technical Specifications: Electronic Health Record System

Technical specifications for electronic health record systems are developed for all measures after they are approved.

Technical Specifications: Prospective Data Collection Flowsheet

Prospective data collection flowsheets are developed for measure sets after they are approved.

References

[1] Saag KG, Teng GG, Patkar NM, Anuntiyo J, Finney C, Curtis JR, et al. American College of Rheumatology 2008 Recommendations for the Use of Nonbiologic and Biologic Disease-Modifying Antirheumatic Drugs in Rheumatoid Arthritis. Arthritis Rheum 2008:59(6): 762---784.

Rheumatoid Arthritis

Measure #3: Functional Status Assessment

Measure Description

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within twelve months.

Measure Detail

Numerator	Patients for whom a functional status assessment was performed at least once within twelve months Definitions: Documentation of an assessment using a standardized descriptive or numeric scale, standardized questionnaire, or notation of assessment of the impact of RA on patient activities of daily living. Examples of tools used to assess functional status include: Health Assessment Questionnaire (HAQ), Modified HAQ, HAQ-2; American College of Rheumatology's Classification of Functional Status in Rheumatoid Arthritis Activities of Daily Living could include a description of any of the following: dressing/grooming, rising from sitting, walking/running/ability to ambulate, stairclimbing, reaching, gripping, shopping/running errands/house or yard work.
Denominator	Patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)
Denominator Exclusions	None
Supporting Guideline	The following evidence statements are quoted <u>verbatim</u> from the referenced clinical guidelines. The management of RA is an iterative process, and patients should be periodically reassessed for evidence of disease activity…or limitation of function with significant alteration of joint anatomy. Baseline evaluation of disease activity and damage in patients with rheumatoid arthritis [should include evaluation of] functional status or quality of life assessments using standardized questionnaires, a physician's global assessment of disease activity, or patient's global assessment of disease activity. (ACR, 2002)[1] The initial evaluation of the patient with RA should document symptoms of active disease (i.e., presence of joint pain, duration of morning stiffness, degree of fatigue), functional status, objective evidence of disease activity (i.e., synovitis, as assessed by tender and swollen joint counts, and the erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level), mechanical joint problems (i.e., loss of motion, crepitus, instability, malalignment, and/or deformity), the presence of extraarticular disease, and the presence of radiographic damage. (ACR, 2002)[1] At each follow up visit, the physician must assess whether the disease is active or inactive. Symptoms of inflammatory (as contrasted with mechanical) joint disease, which include prolonged morning stiffness, duration of fatigue, and active synovitis on joint examination, indicate active disease and necessitate consideration of changing the treatment program. Occasionally, findings of the joint examination alone may not adequately reflect disease activity and structural damage; therefore, periodic measurements of the ESR or CRP level and functional status, as well as radiographic examinations of involved joints should be performed. It is important to determine whether a decline in function is the result of inflammation, mechanical damage, or both; treatment strategies will differ accordingly. (ACR, 2002)[1]

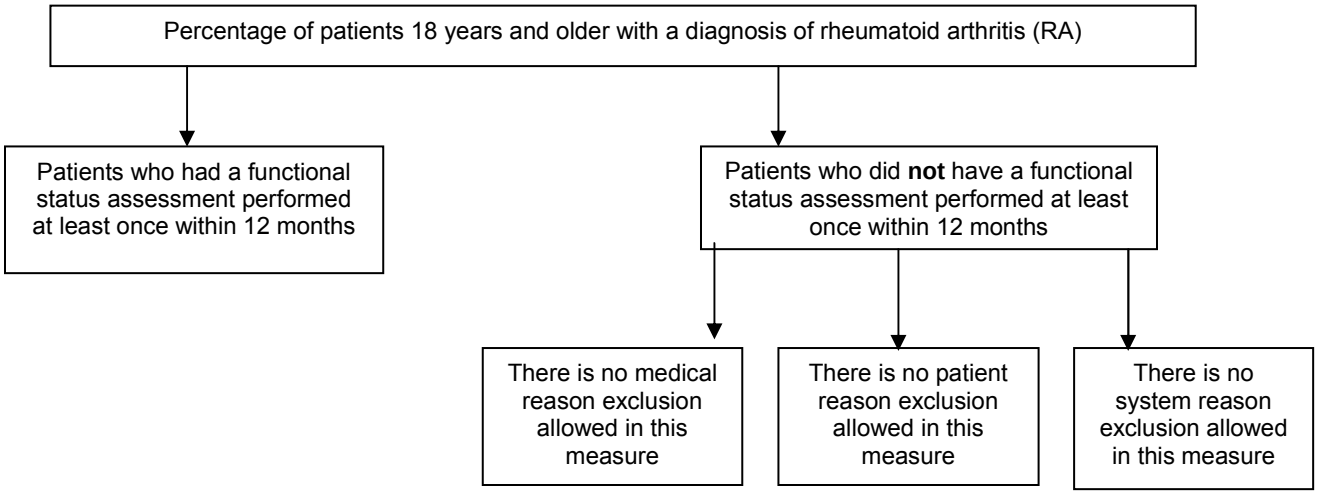
Measure Importance

Relationship to desired outcome	Functional limitations are a significant and disruptive complication for patients living with RA. Assessments of functional limitations are used to assess prognosis and guide treatment and therapy decisions. Functional status should be assessed at the baseline and each follow-up visit, using questionnaires such as the ACR's Classification of Functional Status in RA or the Health Assessment Questionnaire or an assessment of activities of daily living. Regardless of the assessment tool used, it should indicate whether a functional decline is due to inflammation, mechanical damage, or both, as treatment strategies will vary accordingly.
Opportunity for Improvement	While there are a limited number of studies that investigate gaps in care for patients with rheumatoid arthritis, the research that does exist identifies opportunities for improvement in several care areas: 1) there is a lack of adherence to RA guidelines, most noticeably in the use of disease-modifying antirheumatic drugs, and 2) variations in care by practice setting, geographic region and physician specialty. One study analyzed quality of care for 1,355 patients with rheumatoid arthritis using data from a national health plan. Using process measures, the study found that patients with rheumatoid arthritis often did not receive the recommended care suggested by clinical guidelines (for each person-year, recommended processes of care for rheumatoid arthritis were performed an average 62% of the time). The study also found that the quality of care provided to patients with RA varied according to provider type (patients seeing a rheumatologist had higher quality care than those seeing a primary care physician).[2] Similar results were reported by a cohort study of 1,025 patients with RA. Based on certain outcome measures (including pain rating, number of painful joints, and functional status), patients with a rheumatologist as their RA physician had significantly better outcomes than patients whose main RA physician was a non-rheumatologist.[3] Variation and room for improvement will be demonstrated for this measure during pilot testing.
Exclusion Justification	This measure has no exclusions.
Harmonization with Existing Measures	There are no existing measures for functional status screening in RA patients.

Measure Designation

Measure purpose	• Quality Improvement • Accountability
Type of measure	• Process
Care setting	• Ambulatory Care
Data source	• Administrative claims • Medical record • Electronic medical record • Administrative claims supplemented by medical record • Registries • Prospective data collection flowsheet

Actionable Feedback



Technical Specifications: Administrative Data

Denominator (Eligible Population)	Patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) CPT E/M Service Code: • 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99455, 99456 AND ICD-9 Code for RA: • 714.0, 714.1, 714.2, 714.81
Numerator	Patients for whom a functional status assessment was performed at least once within twelve months CPT Category II code: • 1170F – Functional status assessed Definitions: Documentation of an assessment using a standardized descriptive or numeric scale, standardized questionnaire, or notation of assessment of the impact of RA on patient activities of daily living. Examples of tools used to assess functional status include: Health Assessment Questionnaire (HAQ), Modified HAQ, HAQ-2; American College of Rheumatology's Classification of Functional Status in Rheumatoid Arthritis Activities of Daily Living: could include a description of any of the following: dressing/grooming, rising from sitting, walking/running/ability to ambulate, stairclimbing, reaching, gripping, shopping/running errands/house or yard work.
Denominator Exclusions	None

Technical Specifications: Electronic Health Record System

Technical specifications for electronic health record systems are developed for all measures after they are approved.

Technical Specifications: Prospective Data Collection Flowsheet

Prospective data collection flowsheets are developed for measure sets after they are approved.

References

[1] American College of Rheumatology Subcommittee on Rheumatoid Arthritis Guidelines. Arth Rheum. 2002; 46(2):328-346
[2] MacLean CH, Louie R, Leake B, et al. Quality of care for patients with rheumatoid arthritis. *JAMA*. 2000; 284:984–992.
[3] Yelin E, Such C, Criswell L, et al. Outcomes for persons with rheumatoid arthritis with a rheumatologist versus nonrheumatologist as the main physician for this condition. *Med Care*. 1998; 36:513–522.

Rheumatoid Arthritis

Measure #4: Assessment and Classification of Disease Prognosis

Measure Description

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months.

Measure Detail

Numerator	Patients with at least one documented assessment and classification (good/poor) of disease prognosis* utilizing clinical markers of poor prognosis** within 12 months *Poor prognosis: RA patients with features of poor prognosis have active disease with high tender and swollen joint counts, often have evidence of radiographic erosions, elevated levels of rheumatoid factor (RF) and or anti-cyclic citrullinated peptide (anti-CCP) antibodies, and an elevated erythrocyte sedimentation rate, and an elevated C-reactive protein level. ** Prognostic classification should be based upon at a minimum the following markers of poor prognosis: functional limitation (e.g., HAQ Disability Index), extraarticular disease (e.g. vasculitis, Sjorgen's syndrome, RA lung disease, rheumatoid nodules), RF positivity, positive anti-CCP antibodies (both characterized dichotomously, per CEP recommendation), and/or bony erosions by radiography
Denominator	Patients 18 years and older with a diagnosis of Rheumatoid Arthritis (RA)
Denominator Exclusions	None
Supporting Guideline	The following evidence statement is quoted verbatim from the referenced clinical guideline. Poor prognosis is suggested by earlier age at disease onset, high titer of rheumatoid factor (RF), elevated erythrocyte sedimentation rate (ESR), and swelling of >20 joints. Extraarticular manifestations of RA, such as rheumatoid nodules, Sjogren's syndrome, episcleritis and scleritis, interstitial lung disease, pericardial involvement, systemic vasculitis, and Felty's syndrome, may also indicate a worse prognosis…Since studies have demonstrated that treatment with DMARDs may alter the disease course in patients with recent-onset RA, particularly those with unfavorable prognostic factors, aggressive treatment should be initiated as soon as the diagnosis has been established. (Level C evidence) (ACR, 2002)[1] The following evidence statement is adapted from the referenced clinical guideline. Assessment of prognosis should be performed at baseline, before starting medications, to assess organ dysfunction due to comorbid diseases. The literature agrees that a thorough assessment includes recording a complete blood cell count, electrolyte levels, creatinine levels, hepatic enzyme levels (AST- aspartate aminotransferase, ALT- alanine aminotransferase, and albumin), and performing a urinalysis and stool guaiac. If necessary prognosis at baseline should rule out other diseases; this may be repeated during disease flares to rule out septic arthritis through synovial fluid analysis (Level C evidence) (ACR, 2008)[2]

Measure Importance

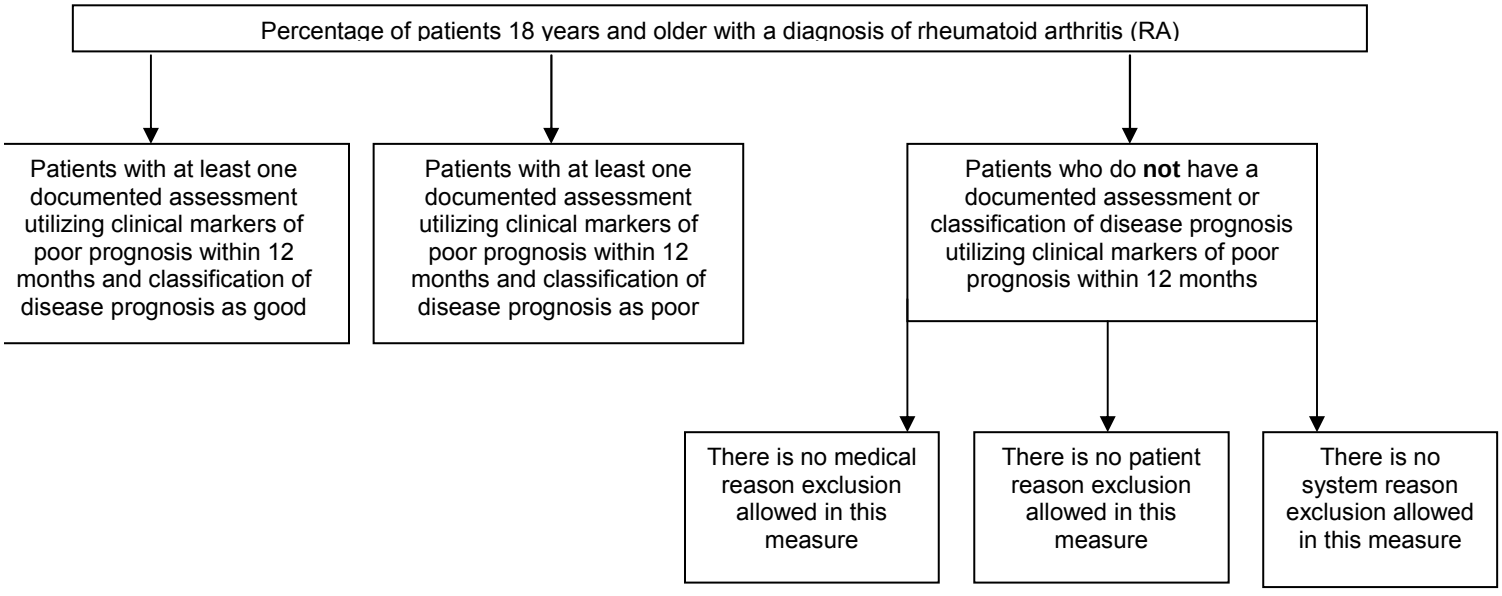
Relationship to desired outcome	After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the presence of these prognostic factors at the time of the treatment decision.[2]
Opportunity for Improvement	While there are a limited number of studies that investigate gaps in care for patients with rheumatoid arthritis, the research that does exist identifies opportunities for improvement in

	several care areas: 1) there is a lack of adherence to RA guidelines, most noticeably in the use of disease-modifying antirheumatic drugs, and 2) variations in care by practice setting, geographic region and physician specialty. One study analyzed quality of care for 1,355 patients with rheumatoid arthritis using data from a national health plan. Using process measures, the study found that patients with rheumatoid arthritis often did not receive the recommended care suggested by clinical guidelines (for each person-year, recommended processes of care for rheumatoid arthritis were performed an average 62% of the time). The study also found that the quality of care provided to patients with RA varied according to provider type (patients seeing a rheumatologist had higher quality care than those seeing a primary care physician).[3] Similar results were reported by a cohort study of 1,025 patients with RA. Based on certain outcome measures (including pain rating, number of painful joints, and functional status), patients with a rheumatologist as their RA physician had significantly better outcomes than patients whose main RA physician was a non-rheumatologist.[4]
Exclusion Justification	This measure has no exclusions.
Harmonization with Existing Measures	There are no existing measures for disease prognosis in RA patients.

Measure Designation

Measure purpose	• Quality Improvement • Accountability
Type of measure	• Process
Care setting	• Ambulatory Care
Data source	• Administrative claims • Medical record • Electronic medical record • Administrative claims supplemented by medical records • Registries • Prospective data collection flowsheet

Actionable Feedback



Technical Specifications: Administrative Data

Denominator (Eligible Population)	Patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) CPT E/M Service Code: • 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99455, 99456 AND ICD-9 Code for Diagnosis: • 714.0, 714.1, 714.2, 714.81
Numerator	Patients with at least one documented assessment and classification (good/poor) of disease prognosis utilizing clinical markers of poor prognosis within 12 months. Definitions: Poor prognosis: RA patients with features of poor prognosis have active disease with high tender and swollen joint counts, often have evidence of radiographic erosions, elevated levels of rheumatoid factor (RF) and or anti-cyclic citrullinated peptide (anti-CCP) antibodies, and an elevated erythrocyte sedimentation rate, and an elevated C-reactive protein level. Prognostic classification should be based upon at a minimum the following markers of poor prognosis: functional limitation (e.g., HAQ Disability Index), extraarticular disease (e.g. vasculitis, Sjorgen's syndrome, RA lung disease, rheumatoid nodules), RF positivity, positive anti-CCP antibodies (both characterized dichotomously, per CEP recommendation), and/or bony erosions by radiography CPT Category II code: • 3475F – Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented OR • 3476F – Disease prognosis for rheumatoid arthritis assessed, good prognosis documented
Denominator Exclusions	None

Technical Specifications: Electronic Health Record System

Technical specifications for electronic health record systems are developed for all measures after they are approved.

Technical Specifications: Prospective Data Collection Flowsheet

Prospective data collection flowsheets are developed for measure sets after they are approved.

References

[1] American College of Rheumatology Subcommittee on Rheumatoid Arthritis Guidelines. Arth Rheum. 2002; 46(2):328-346

[2] Saag KG, Teng GG, Patkar NM, Anuntiyo J, Finney C, Curtis JR, et al. American College of Rheumatology 2008 Recommendations for the Use of Nonbiologic and Biologic Disease-Modifying Antirheumatic Drugs in Rheumatoid Arthritis. Arthritis Rheum 2008:59(6): 762---784.

[3] MacLean CH, Louie R, Leake B, et al. Quality of care for patients with rheumatoid arthritis. *JAMA*. 2000; 284:984–992.

[4] Yelin E, Such C, Criswell L, et al. Outcomes for persons with rheumatoid arthritis with a rheumatologist versus nonrheumatologist as the main physician for this condition. *Med Care*. 1998; 36:513–522.

Rheumatoid Arthritis

Measure #5: Glucocorticoid Management

Measure Description

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone > 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months

Measure Detail

Numerator	Patients who have been assessed for glucocorticoid use at least once within 12 months, and for those on prolonged doses* of prednisone > 10 mg qD (or equivalent**) with improvement or no change in disease activity, documentation of a glucocorticoid management plan*** *Prolonged doses are doses >6 months in duration **Prednisone equivalents can be determined using the following: 1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone[1] ***Glucocorticoid management plan: documentation of attempt to taper steroids OR documentation of a new prescription for a non-glucocorticoid DMARD OR increase in dose of non-glucocorticoid DMARD dose for persistent RA disease activity at current or reduced dose
Denominator	Patients 18 years and older with a diagnosis of rheumatoid arthritis
Denominator Exclusions	Documentation of medical reason(s) for not documenting glucorticoid dose (i.e., glucocorticoid prescription is for a medical condition other than RA)
Supporting Guideline	The following evidence statements are quoted <u>verbatim</u> from the referenced clinical guidelines. The benefits of low-dose systemic glucocorticoids, however, should always be weighed against their adverse effects. The adverse effects of long-term oral glucocorticoids at low doses are protean and include osteoporosis, hypertension, weight gain, fluid retention, hyperglycemia, cataracts, and skin fragility, as well as the potential for premature atherosclerosis. These adverse effects should be considered and should be discussed in detail with the patient before glucocorticoid therapy is begun. For long term disease control, the glucocorticoid dosage should be kept to a minimum. For the majority of patients with RA, this means £10 mg of prednisone per day. (ACR, 2002)[2]

Measure Importance

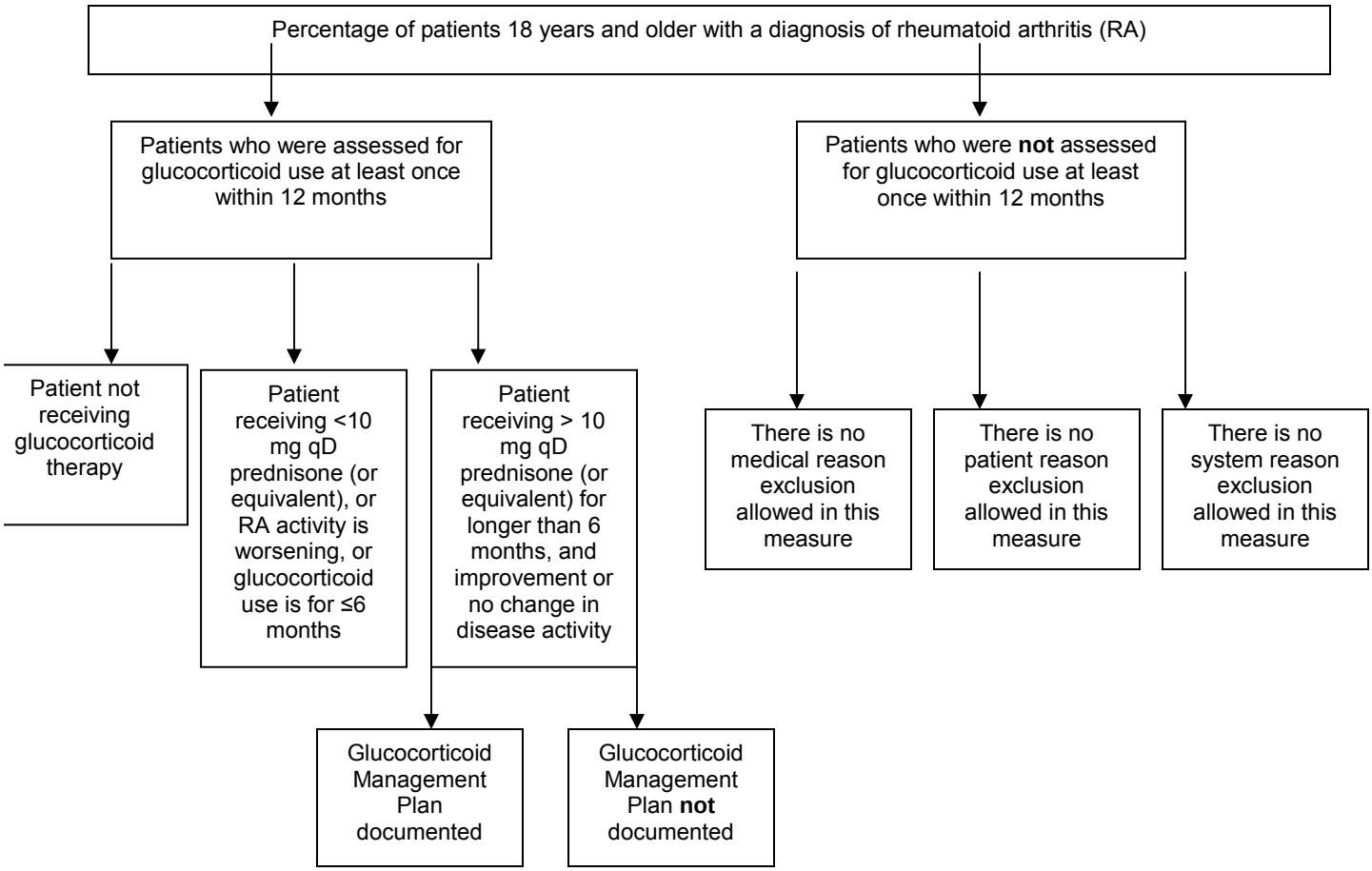
Relationship to desired outcome	Glucocorticoids are an important part of RA treatment as they inhibit inflammation and may control synovitis. However, long-term use of glucocorticoids, especially at high doses, should be avoided, due to the potential health complications. Monitoring length and dose of glucocorticoid treatment for patients with RA is integral to making other clinical decisions (e.g., prescribing vitamin D and calcium supplements, initiating antiresorptive therapy, ordering a dual energy X-ray absorptiometry scan to assess bone mineral density, and tapering the steroid dose).[3,4]
Opportunity for Improvement	While there are a limited number of studies that investigate gaps in care for patients with rheumatoid arthritis, the research that does exist identifies opportunities for improvement in several care areas: 1) there is a lack of adherence to RA guidelines, most noticeably in the use of disease-modifying antirheumatic drugs, and 2) variations in care by practice setting, geographic region and physician specialty.

	One study analyzed quality of care for 1,355 patients with rheumatoid arthritis using data from a national health plan. Using process measures, the study found that patients with rheumatoid arthritis often did not receive the recommended care suggested by clinical guidelines (for each person-year, recommended processes of care for rheumatoid arthritis were performed an average 62% of the time). The study also found that the quality of care provided to patients with RA varied according to provider type (patients seeing a rheumatologist had higher quality care than those seeing a primary care physician).[5] Similar results were reported by a cohort study of 1,025 patients with RA. Based on certain outcome measures (including pain rating, number of painful joints, and functional status), patients with a rheumatologist as their RA physician had significantly better outcomes than patients whose main RA physician was a non-rheumatologist.[6]
Exclusion Justification	This measure has no exclusions.
Harmonization with Existing Measures	There are no existing measures for disease prognosis in RA patients.

Measure Designation

Measure purpose	• Quality Improvement • Accountability
Type of measure	• Process
Care setting	• Ambulatory Care
Data source	• Administrative claims • Medical record • Electronic medical record • Administrative claims supplemented by medical record • Registries • Prospective data collection flowsheet

Actionable Feedback



Technical Specifications: Administrative Data

Denominator (Eligible Population)	Patients 18 years and older with a diagnosis of rheumatoid arthritis CPT E/M Service Code: • 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99455, 99456 AND ICD-9 Code for Diagnosis: • 714.0, 714.1, 714.2, 714.81
Numerator	Patients who have been assessed for glucocorticoid use at least once within 12 months, and for those on prolonged doses of prednisone 10 mg qD (or equivalent) with improvement or no change in disease activity, documentation of a glucocorticoid management plan CPT Category II code: • 4192F – Patient not receiving glucocorticoid therapy OR CPT Category II code: • 4193F – Patient receiving <10 mg daily prednisone (or equivalent), or RA activity is worsening, or glucocorticoid use is for <6 months OR CPT Category II code: • 4194F – Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity AND CPT Category II code: • 0540F – Glucocorticoid Management Plan documented Definitions: Prolonged doses are doses >6 months in duration Prednisone equivalents can be determined using the following: 1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone[7] Glucocorticoid management plan: documentation of attempt to taper steroids OR documentation of a new prescription for a non-glucocorticoid DMARD OR increase in dose of non-glucocorticoid DMARD dose for persistent RA disease activity at current or reduced dose
Denominator Exclusions	Documentation of medical reason(s) for not documenting glucorticoid dose (i.e., glucocorticoid prescription is for a medical condition other than RA)

Technical Specifications: Electronic Health Record System

Technical specifications for electronic health record systems are developed for all measures after they are approved.

Technical Specifications: Prospective Data Collection Flowsheet

Prospective data collection flowsheets are developed for measure sets after they are approved.

References

[1] Wei L, MacDonal TM, Walker BR. Taking glucocorticoids by prescription is associated with subsequent cardiovascular disease. *Ann Intern Med*. 2004; 141:764-770.
[2] American College of Rheumatology Subcommittee on Rheumatoid Arthritis Guidelines. *Arth Rheum*. 2002; 46(2): 339.
[3] Khanna D, Arnold EL, Pencharz JN, et al. Measuring process of arthritis care: The Arthritis Foundation's quality indicator set for rheumatoid arthritis. *Semin Arthritis Rheum*. 2006; 35:211-237.
[4] Luqmani R, Hennell S, Estrach C, et al. British Society for Rheumatology and British Health Professionals in Rheumatology guideline for the management of rheumatoid arthritis (the first 2 years). *Rheumatology*. 2006:1-16.
[5] MacLean CH, Louie R, Leake B, et al. Quality of care for patients with rheumatoid arthritis. *JAMA*. 2000; 284:984–992.
[6] Yelin E, Such C, Criswell L, et al. Outcomes for persons with rheumatoid arthritis with a rheumatologist versus nonrheumatologist as the main physician for this condition. *Med Care*. 1998; 36:513–522.
[7] Wei L, MacDonal TM, Walker BR. Taking glucocorticoids by prescription is associated with subsequent cardiovascular disease. *Ann Intern Med*. 2004; 141:764-770.

