RHEUMATOID ARTHRITIS (RA) MEASURES GROUP OVERVIEW

2016 PQRS OPTIONS FOR MEASURES GROUPS:

2016 PQRS MEASURES IN RHEUMATOID ARTHRITIS (RA) MEASURES GROUP:
#108  Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy
#128  Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
#131  Pain Assessment and Follow-Up
#176  Rheumatoid Arthritis (RA): Tuberculosis Screening
#177  Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
#178  Rheumatoid Arthritis (RA): Functional Status Assessment
#179  Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
#180  Rheumatoid Arthritis (RA): Glucocorticoid Management
#337  Tuberculosis Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier

INSTRUCTIONS FOR REPORTING:

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

  G8490: I intend to report the Rheumatoid Arthritis Measures Group

- Report the patient sample method:
  20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2016).

- Patient sample criteria for the RA Measures Group are patients aged 18 years and older with a specific diagnosis of RA accompanied by a specific patient encounter:

  One of the following diagnosis codes indicating rheumatoid arthritis:

  ICD-10-CM: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9,
Accompanied by:

**One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

- To report satisfactorily the RA Measures Group it requires **all applicable** measures, for each patient within the eligible professional’s patient sample, to be reported a minimum of once during the reporting period.

- Measure #128 does not need to be reported (is not applicable) if the patient is considered not eligible for BMI calculation or follow-up plan – A patient is not eligible if one or more of the following reasons are documented:
  - Patient is receiving palliative care
  - Patient is pregnant
  - Patient refuses BMI measurement (refuses height and/or weight)
  - Any other reason documented in the medical record by the provider why BMI measurement was not appropriate
  - Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient’s health status

- When reporting measure #131, the documented follow-up plan must be related to the presence of pain, example: “Patient referred to pain management specialist for back pain” or “Return in two weeks for reassessment of pain”.

- Measure #337 is only applicable if the patient is on a biologic immune response modifier prescribed by the provider reporting the measures group (G9506 or equivalent).

- Instructions for qualifying numerator option reporting for each of the measures within the Rheumatoid Arthritis (RA) Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.

**Composite QDC G8499:** All quality actions for the applicable measures in the Rheumatoid Arthritis Measures Group have been performed for this patient

- **Measure Group Reporting Calculations:**

  Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each applicable measure within the measures group reported by the eligible professional.
Performance exclusion QDCs are not counted in the performance denominator. If the eligible professional submits all performance exclusion QDCs, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening for Osteoporosis for Women Aged 65-85 Years of Age would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

- **NOTE:** The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures group option.
**Measure #108 (NQF 0054): Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy -- National Quality Strategy Domain: Effective Clinical Care**

**DESCRIPTION:**
Percentage of patients aged 18 years and older who were diagnosed with rheumatoid arthritis and were prescribed, dispensed, or administered at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD)

**NUMERATOR:**
Patients who were prescribed, dispensed, or administered at least one disease modifying anti-rheumatic drug (DMARD) during the measurement period

**Definition:**
*Prescribed* – May include prescription given to the patient for DMARD therapy at one or more visits in the 12-month period OR patient already taking DMARD therapy as documented in current medication list.

**Table 6 - The DMARDs listed below are considered DMARDs for the purposes of this measure**

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
<th>J Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Aminosalicylates</td>
<td>• Sulfasalazine</td>
<td>N/A</td>
</tr>
<tr>
<td>Alkylating agents</td>
<td>• Cyclophosphamide</td>
<td>N/A</td>
</tr>
<tr>
<td>Aminoquinolines</td>
<td>• Hydroxychloroquine</td>
<td>N/A</td>
</tr>
<tr>
<td>Anti-rheumatics</td>
<td>• Auranofin</td>
<td>J1600, J9250,</td>
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<tr>
<td></td>
<td>• Gold sodium thiomalate</td>
<td>J9260</td>
</tr>
<tr>
<td></td>
<td>• Leflunomide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Methotrexate</td>
<td></td>
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<tr>
<td></td>
<td>• Penicillamine</td>
<td></td>
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<tr>
<td>Immunomodulators</td>
<td>• Abatacept</td>
<td>J0129, J0135,</td>
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<tr>
<td></td>
<td>• Adalimumab</td>
<td>J0717, J0718,</td>
</tr>
<tr>
<td></td>
<td>• Anakinra</td>
<td>J1438, J1602,</td>
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<tr>
<td></td>
<td>• Certolizumab</td>
<td>J1745, J3262,</td>
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<tr>
<td></td>
<td>• Certolizumab pegol</td>
<td>J9310</td>
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<tr>
<td></td>
<td>• Etanercept</td>
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<tr>
<td></td>
<td>• Golimumab</td>
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<tr>
<td></td>
<td>• Infliximab</td>
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<tr>
<td></td>
<td>• Rituximab</td>
<td></td>
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<tr>
<td></td>
<td>• Tocilizumab</td>
<td></td>
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<tr>
<td>Immunosuppressive agents</td>
<td>• Azathioprine</td>
<td>J7502, J7515,</td>
</tr>
<tr>
<td></td>
<td>• Cyclosporine</td>
<td>J7516, J7517,</td>
</tr>
<tr>
<td></td>
<td>• Mycophenolate</td>
<td>J7518</td>
</tr>
<tr>
<td>Janus kinase (JAK) Inhibitor</td>
<td>• Tofacitinib</td>
<td>N/A</td>
</tr>
<tr>
<td>Tetracyclines</td>
<td>• Minocycline</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Note: J codes should only be used to identify if the appropriate DMARD therapy was prescribed to the patient. CPT II codes are used when reporting this measure.*
**Numerator Options:**

**Performance Met:** Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered (4187F)

OR

**Medical Performance Exclusion:** Documentation of medical reason(s) for not prescribing, dispensing, or administering disease modifying anti-rheumatic drug therapy (ie, patients with a diagnosis of HIV or pregnancy) (4187F with 1P)

OR

**Performance Not Met:** Disease modifying anti-rheumatic drug therapy was not prescribed, dispensed, or administered, reason not otherwise specified (4187F with 8P)
Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan -- National Quality Strategy Domain: Community/Population Health

DESCRIPTION:
Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

Normal Parameters:
- Age 65 years and older BMI ≥ 23 and < 30 kg/m2
- Age 18 – 64 years BMI ≥ 18.5 and < 25 kg/m2

NUMERATOR:
Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

Numerator Instructions:
- Height and Weight – An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.
- Follow-Up Plan – If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, example: “Patient referred to nutrition counseling for BMI above normal parameters.” (See Definitions for examples of a follow-up plan treatments)
- Performance Met for G8417 & G8418
  - If the provider documents a BMI and a follow-up plan at the current visit OR
  - If the patient has a documented BMI within the previous six months of the current encounter, the provider documents a follow-up plan at the current visit OR
  - If the patient has a documented BMI within the previous six months of the current encounter AND the patient has a documented follow-up plan for a BMI outside normal parameters within the previous six months of the current visit

Definitions:
BMI – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H2) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))

OR

English Units: BMI = Weight (lbs) / (Height (in) x Height (in)) x 703

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include but is not limited to:
- Documentation of education
- Referral (e.g., a registered dietitian/nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon)
- Pharmacological interventions
- Dietary supplements
• Exercise counseling
• Nutrition counseling

Not Eligible for BMI Calculation or Follow-Up Plan – A patient is not eligible if one or more of the following reasons are documented:
• Patient is receiving palliative care
• Patient is pregnant
• Patient refuses BMI measurement (refuses height and/or weight)
• Any other reason documented in the medical record by the provider why BMI measurement was not appropriate
• Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient’s health status

Numerator Options:
Performance Met:
BMI is documented within normal parameters and no follow-up plan is required (G8420)

OR
Performance Met:
BMI is documented above normal parameters and a follow-up plan is documented (G8417)

OR
Performance Met:
BMI is documented below normal parameters and a follow-up plan is documented (G8418)

OR
Performance Not Met:
BMI not documented and no reason is given (G8421)

OR
Performance Not Met:
BMI documented outside normal parameters, no follow-up plan documented, no reason given (G8419)
Measure #131 (NQF 0420): Pain Assessment and Follow-Up -- National Quality Strategy Domain: Communication and Care Coordination

DESCRIPTION:
Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

NUMERATOR:
Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present

Definitions:
Pain Assessment - Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.

Standardized Tool – An assessment tool that has been appropriately normed and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS) and Visual Analog Scale (VAS).

Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This must include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions.

Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: The standardized tool used to assess the patient's pain must be documented in the medical record (exception: A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity).

Numerator Options:
Performance Met: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented (G8730)

OR
Performance Met: Pain assessment using a standardized tool is documented as negative, no follow-up plan required (G8731)

OR
Other Performance Exclusion: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool (G8442)
OR
Other Performance Exclusion:

Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible (G8939)

OR

Performance Not Met:

No documentation of pain assessment, reason not given (G8732)

OR

Performance Not Met:

Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given (G8509)
Measure #176: Rheumatoid Arthritis (RA): Tuberculosis Screening -- National Quality Strategy
Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients aged 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 anti-rheumatic drug (DMARD)

**NUMERATOR:**
Patients for whom a TB screening was performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic DMARD

**Numerator Instructions:** Patients are considered to be receiving a first course of therapy using a biologic DMARD only if they have never previously been prescribed or dispensed a biologic DMARD.

**Definition:**
Biologic DMARD Therapy – Includes Adalimumab, Etanercept, Infliximab, Abatacept, Anakinra (Rituximab is excluded).

**Numerator Options:**

- **Performance Met:**
  - TB screening performed and results interpreted within six months prior to initiation of first-time biologic disease modifying anti-rheumatic drug therapy for RA (3455F)
  - AND
  - Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (4195F)

- **Medical Performance Exclusion:**
  - Documentation of medical reason for not screening for TB or interpreting results (ie, patient positive for TB and documentation of past treatment; patient who has recently completed a course of anti-TB therapy) (3455F with 1P)
  - AND
  - Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (4195F)

- **Other Performance Exclusion:**
  - Patient not receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (4196F)

- **Performance Not Met:**
  - TB screening not performed or results not interpreted, reason not otherwise specified (3455F with 8P)
  - AND
  - Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (4195F)
Measure #177: Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease activity within 12 months

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

Definition:
Assessment and Classification of Disease Activity – Assesses if physicians are utilizing a standardized, systematic approach for evaluating 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.

NUMERATOR NOTE: If the physician uses an alternate, standardized, systematic approach for evaluating the level of disease activity other than the tools listed above, that will be numerator compliant.

Numerator Options:

Performance Met: Rheumatoid arthritis (RA) disease activity, low (3470F)
OR
Performance Met: Rheumatoid arthritis (RA) disease activity, moderate (3471F)
OR
Performance Met: Rheumatoid arthritis (RA) disease activity, high (3472F)
OR
Performance Not Met: Disease activity not assessed and classified, reason not otherwise specified (3470F with 8P)
Measure #178: Rheumatoid Arthritis (RA): Functional Status Assessment -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months

NUMERATOR:
Patients for whom a functional status assessment was performed at least once within 12 months

Definitions:
Functional Status Assessment – This measure assesses if physicians are 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 but are not limited to: 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, stair climbing, reaching, gripping, shopping/running errands/house or yard work.

Numerator Options:
Performance Met: Functional status assessed (1170F)

OR

Performance Not Met: Functional status not assessed, reason not otherwise specified (1170F with 8P)
Measure #179: Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
-- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients aged 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

**NUMERATOR:**
Patients with at least one documented assessment and classification (good/poor) of disease prognosis utilizing clinical markers of poor prognosis within 12 months

**Numerator Instructions:** This measure evaluates if physicians are assessing and classifying disease prognosis using a standardized, systematic approach. Disease prognosis should be classified as either poor or good.

**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.

**Clinically Important Markers of Poor Prognosis** – Classification should be based upon at a minimum the following: 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.

**Numerator Options:**

**Performance Met:**
- Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented (3475F)

**OR**

**Performance Met:**
- Disease prognosis for rheumatoid arthritis assessed, good prognosis documented (3476F)

**OR**

**Performance Not Met:**
- Disease prognosis for rheumatoid arthritis not assessed and classified, reason not otherwise specified (3475F with 8P)
Measure #180: Rheumatoid Arthritis (RA): Glucocorticoid Management -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients aged 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

NUMERATOR:
Patients 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 a glucocorticoid management plan within 12 months

Definitions:
Prolonged Dose – Doses > 6 months in duration.
Prednisone Equivalents – Determine 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.
Glucocorticoid Management Plan – Includes documentation of attempt to taper steroids OR documentation of a new prescription for a non-glucocorticoid disease-modifying anti-rheumatic drug (DMARD) OR increase in dose of non-glucocorticoid DMARD dose for persistent RA disease activity at current or reduced dose.

Numerator Options:
Performance Met:
Patient not receiving glucocorticoid therapy (4192F)
OR
Performance Met:
Patient receiving < 10 mg daily prednisone (or equivalent), or RA activity is worsening, or glucocorticoid use is for less than 6 months (4193F)

OR
Performance Met:
Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity (4194F)

AND
Glucocorticoid Management Plan documented (0540F)

OR
Medical Performance Exclusion:
Documentation of medical reason(s) for not documenting glucocorticoid management plan (ie, glucocorticoid prescription is for a medical condition other than RA) (0540F with 1P)

AND
Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity (4194F)

OR
Performance Not Met:
Glucocorticoid dose was not documented, reason not otherwise specified (4194F with 8P)

OR
Performance Not Met: Glucocorticoid management plan not documented, reason not otherwise specified (0540F with 8P)

AND

Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity (4194F)
Measure #337: Tuberculosis Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient’s history to determine if they have had appropriate management for a recent or prior positive test.

NUMERATOR:
Patients who have a documented negative annual TB screening or have documentation of the management of a positive TB screening test with no evidence of active tuberculosis, confirmed through use of radiographic imaging (i.e., chest x-ray, CT).

Definition:
Biologic Immune Response Modifier –
1) TNF-alpha inhibitors, to include, but not limited to Infliximab (Remicade), Adalimumab (Humira), Etanercept (Enbrel), or Golimumab (Simponi), Certolizumab (Cimzia).
2) Inhibitors of IL-12 and/or IL-23 or their receptors to include but not limited to Ustekinumab (Stelara).
3) B7 inhibitors, to include but not limited to Abatacept (Orencia).
4) Inhibitors of IL-17 family members or their receptors.

Numerator Options:
Performance Met: Documentation of negative or managed positive TB screen with further evidence that TB is not active (G9359)

OR

Performance Not Met: No documentation of negative or managed positive TB screen (G9360)
MEASURE #108 - RHEUMATOID ARTHRITIS (RA): DISEASE MODIFYING ANTI-RHEUMATIC DRUG (DMARD) THERAPY
RATIONALE:
Early diagnosis and management of RA presents an important opportunity to alter the course of this progressive disease. Treatment in the first few months after disease onset takes advantage of a window of opportunity to effectively limit structural damage to joints and improves health outcomes. American College of Rheumatology (ACR) guidelines underscore early DMARD therapy.

CLINICAL RECOMMENDATION STATEMENTS:
The American College of Rheumatology (ACR) recommends targeting either low disease activity or remission in all patients with early RA (level of evidence C) and established RA (level of evidence C) receiving any DMARD or biologic agent.

In patients with early RA, the ACR recommends the use of DMARD monotherapy both for low disease activity and for moderate or high disease activity with the absence of poor prognostic features (level of evidence A–C). In patients with early RA, the ACR recommends the use of DMARD combination therapy (including double and triple therapy) in patients with moderate or high disease activity plus poor prognostic features (level of evidence A–C). In patients with early RA, the ACR also recommends the use of an anti-TNF biologic with or without methotrexate in patients who have high disease activity with poor prognostic features (level of evidence A and B). Infliximab is the only exception and the recommendation is to use it in combination with methotrexate, but not as monotherapy.

MEASURE #128 - PREVENTIVE CARE AND SCREENING: BODY MASS INDEX (BMI) SCREENING AND FOLLOW-UP PLAN
RATIONALE:
Normal Parameters for Age 65 Years and Older
Winter et al. (2014) performed a meta-analysis looking at the relationship between BMI and all-cause mortality among adults 65 and older. They identified a higher risk of mortality among those with a BMI <23 kg/m2 and recommended monitoring weight status in this group to address any modifiable causes of weight loss promptly with due consideration of individual comorbidities. Dahl et al. (2013) reported that old persons (70–79) who were overweight had a lower mortality risk than old persons who were of normal weight, even after controlling for weight change and multimorbidity. The study also shows that persons who increased or decreased in BMI had a greater mortality risk than those who had a stable BMI, particularly those aged 70 to 79. Their results provide support to the belief that the World Health Organization guidelines for BMI are overly restrictive in old age.

BMI Above Upper Parameters
Obesity continues to be a costly public health concern in the United States. The Centers for Disease Control and Prevention (CDC, 2010) reported in 2009, no state met the Healthy People 2010 obesity target of 15 percent and the self-reported overall prevalence of obesity among adults had increased 1.1 percentage points in 2007 to 26.7 percent (2010). Ogden, Carroll, Kit and Flegal (2013) reported the prevalence of BMI-defined obesity in adults is high and continues to exceed 30% in most sex-age groups (34.9% overall). They also stated the overall prevalence of obesity did not differ between men and women in 2011–2012; however, among non-Hispanic black adults, 56.6% of women were obese compared with 37.1% of men. In addition to the continued high prevalence rate for adults in general, Flegal, Carroll & Kit (2012) report a significant increase for men and for non-Hispanic black and Mexican American women over the 12-year period from 1999 through 2010 (2012). Moyer (2012) reported: Obesity is associated with such health problems as an increased risk for coronary artery disease, type 2 diabetes, various types of cancer, gallstones and disability. These comorbid medical conditions are associated with higher use of health care services and costs among obese patients (p. 373).
Obesity is also associated with an increased risk of death, particularly in adults younger than age 65 years and has been shown to reduce life expectancy by 6 to 20 years depending on age and race (LeBlanc et al., 2011). Masters, et al. (2013) also showed mortality due to obesity varied by race and gender. They estimated adult deaths between 1986 and 2006 associated with overweight and obesity was 5.0% and 15.6% for Black and White men, and 26.8% and 21.7% for Black and White women, respectively. They also found a stronger association than previous research demonstrated between obesity and mortality risk at older ages.

Finkelstein, Trogdon, Cohen and Dietz (2009) found that in 2006, across all payers, per capita medical spending for the obese is $1,429 higher per year, (42 percent) than for someone of normal weight. Using 2008 dollars, this was estimated to be equivalent to $147 billion dollars in medical care costs related to obesity.

Padula, Allen and Nair (2014) examined data from a commercial claims and encounters database to estimate the cost for obesity and associated comorbidities among working-age adults who had a claim with a primary or secondary diagnosis of obesity in 2006-2007. The mean net expenditure for inpatient and outpatient claims was $1,907 per patient per visit. The increases in cost for comorbidities ranged from $527 for obesity with CHF to $15,733 for the combination of obesity, diabetes mellitus, hypertension and depression.

In addition to a high prevalence rate of obesity, less than 50% of obese adults in 2010 received advice to exercise or perform physical activity (Barnes & Schoenborn, 2012).

**BMI Below Normal Parameters**

In the National Center for Health Statistics (NCHS) Health E-Stat, Fryer and Ogden (2012) reported that poor nutrition or underlying health conditions can result in underweight. Results from the 2007-2010 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, indicate an estimated 1.7% of U.S. adults are underweight with women more likely to be underweight than men (2012).

In a cohort study conducted by Borrell and Lalitha (2014), data from NHANES III (1988-1994) was linked to the National Death Index mortality file with follow-up to 2006, and showed that when compared to their normal weight counterparts (BMI 18.5-25 kg/m2), underweight (BMI <18.5 kg/m2) had significantly higher death rates (Hazard Ratio= 2.27; 95% confidence interval (CI) = 1.78, 2.90).

Ranhoff, Gjoen and Mowe (2005) recommended using BMI < 23 kg/m2 for the elderly to identify positive results with malnutrition screens and poor nutritional status.

**CLINICAL RECOMMENDATION STATEMENTS:**

Although multiple clinical recommendations addressing obesity have been developed by professional organizations, societies and associations, two recommendations have been identified which exemplify the intent of the measure and address the numerator and denominator.

The US Preventive Health Services Task Force (USPSTF) recommends screening all adults (aged 18 years and older) for obesity. Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions. This is a B recommendation (Moyer, 2012).

As cited in Wilkinson et al. (2013), Institute for Clinical Systems Improvement (ICSI) Preventive Services for Adults, Obesity Screening (Level II) Recommendation provides the following guidance:

- Record height, weight and calculate body mass index at least annually
- Clinicians should consider waist circumference measurement to estimate disease 25 to 34.9 kg/m², sex risk for patients who have BMI scores indicative of overweight or obesity class I. For adult patients with a BMI of specific waist circumference cutoffs should be used in conjunction with BMI to identify increased disease risk.
• A BMI greater or equal to 30 is defined as obese
• A BMI of 25-29 is defined as overweight
• Intensive intervention for obese individuals, based on BMI, is recommended by the U.S. Preventive Services to help control weight.

Similarly, the 2013 joint report/guideline from the American Heart Association, American College of Cardiology and The Obesity Society also recommend measuring height and weight and calculating BMI at annual visits or more frequently, using the current cutpoints for overweight (BMI>25.0-29.9 kg/m2) and obesity (BMI ≥30 kg/m2) to identify adults who may be at elevated risk of CVD and the current cutpoints for obesity to identify adults who may be at elevated risk of mortality from all causes. They also recommend counseling overweight and obese individuals on their increased risk for CVD, type 2 diabetes, all-cause mortality and need for lifestyle changes.

MEASURE #131 – PAIN ASSESSMENT AND FOLLOW-UP

RATIONALE:
Chronic pain is defined as pain without biological values that has persisted beyond the normal time and despite the usual customary efforts to diagnose and treat the original condition and injury. If a patient’s pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the course of the chronic pain is warranted (ICSI, 2013).

Chronic pain affects approximately 100 million adults in the USA. (Gaskin, 2012). It is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (Mayday Fund, 2009).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women’s pain complaints tend to be poorly assessed and undertreated (Green, 2003; Chronic Pain Research Alliance 2011, Weimer 2013). Although women may have higher baseline pain, differences in pain levels may not persist at one month (Peterson, 2012).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Burgess, 2013; Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007). Black race is associated with neighborhood socio-economic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012)

“When assessing and treating pain, practitioner sex, race, age, and duration of experience were all significantly associated with pain management decisions. These findings suggest that pain assessment and treatment decisions may be impacted by the health care providers’ demographic characteristics, effects which may contribute to pain management disparities.”(Bartley et al., 2015).

“A standard minimum pain assessment for back-pain patients should integrate pain intensity (e.g. VAS/NRS), pain affect (e.g. five-point VRS) and pain-related disability. Depending on more detailed research questions, more sophisticated questionnaires on pain affect (e.g. MPQ), coping strategies and fear-avoidance behavior should be used. This allows for a more comprehensive assessment of pain and factors influencing pain perception.” (Haefeli M., Effering. A., 2005).
The American Pain Foundation (2009) identified pertinent facts related to the impact of pain as follows:

- Approximately 76.5 million Americans suffer from pain.
- Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.
- Uncontrolled pain is a leading cause of disability and diminishes quality of life for patients, survivors, and their loved ones. It interferes with all aspects of daily activity, including sleep, work, social and sexual relations.
- Under-treated pain drives up costs – estimated at $100 billion annually in healthcare expenses, lost income, and lost productivity—extending length of hospital stays, as well as increasing emergency room trips and unplanned clinic visits.
- Medically underserved populations endure a disproportionate pain burden in all health care settings.
- Disparities exist among racial and ethnic minorities in pain perception, assessment, and treatment for all types of pain, whether chronic or acute.

The Institute Of Medicine’s (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) report suggests that chronic pain rates will continue to increase as a result of:

- More Americans will experience a disease in which chronic pain is associated (diabetes, cardiovascular disease, etc.).
- Increase in obesity which is associated with chronic conditions that have painful symptoms.
- Progress in lifesaving techniques for catastrophic injuries for people who would have previously died leads to a group of young people at risk for lifelong chronic pain.
- Surgical patients are at risk for acute and chronic pain.
- The public has a better understanding of chronic pain syndromes and new treatments and therefore may seek help when they may not have sought help in the past.

There are no current estimates of the total cost of poorly controlled pain in today’s dollars. Viewed from the perspective of health care inflation at levels of more than 40% during the past decade (President’s Council of Economic Advisors, 2009), the cost of health care due to pain is estimated to be between $261 to $300 billion. The value of lost productivity based on estimates of days of work missed is $11.6 to 12.7 billion, hours of work lost is 95.2 to 96.5 billion and lower wages is $190.6 to $226.3 billion.

**CLINICAL RECOMMENDATION STATEMENTS:**

Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.

A patient-centered, multifactorial, comprehensive care plan is necessary; one that includes biopsychosocial factors, as well as spiritual and cultural issues. It is important to have an interdisciplinary team approach which includes the primary care physician and specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2013) Assessment and Management of Chronic Pain Guideline, Sixth Edition is based on a very broad foundation of evidence addressing a wide range of clinical conditions. It was chosen because it addresses the key factors of the comprehensive plan of care which incorporates self-management and active input from the patient and primary care clinician, pain assessment outcomes and referral to a pain medicine specialist or pain medicine specialty clinic.

The Institute for Clinical Systems Improvement (ICSI, 2012) Adult Acute and Sub-acute Low Back Pain guideline provides guidelines for physical therapists for low back pain assessment criteria, reducing or eliminating imaging for diagnosis of non-specific low back pain in patients 18 years and older, first-line treatment which emphasizes patient education and a core treatment plan that includes encouraging activity, use of heat, no imaging, cautious and
responsible use of opioids, anti-inflammatory and analgesic over-the-counter medications and return to work assessment, advising patients with acute or subacute low back pain to stay active and the use of opioids.

Low Back Pain: Clinical Guidelines Linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (Delitto, 2012) provides evidence to classify musculoskeletal conditions, specify interventions and identify appropriate outcome measures.

“Initial physical therapy management was not associated with increased health care costs or utilization of specific services following a new primary care LBP consultation” (Fritz, 2013, p. 1).

Anchored numerical scales are recommended for tracking routine progress, particularly pain interference with important activities. Regional or condition functional outcome scales should be routinely used at baseline and periodic follow-ups. More frequent follow-up is recommended with higher frequency care. (Washington State Department of Labor and Industries, 2014)

MEASURE #176 - RHEUMATOID ARTHRITIS (RA): TUBERCULOSIS SCREENING
RATIONALE:
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.

CLINICAL RECOMMENDATION STATEMENTS:
The American College of Rheumatology recommends screening to identify latent TB infection (LTBI) in all RA patients being considered for therapy with biologic agents, regardless of the presence of risk factors for LTBI. (Level of Evidence: C) (ACR, 2012)

MEASURE #177 - RHEUMATOID ARTHRITIS (RA): PERIODIC ASSESSMENT OF DISEASE ACTIVITY
RATIONALE:
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 decisions.

CLINICAL RECOMMENDATION STATEMENTS:
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 our guide, we rated RA disease activity in an ordinal manner as low, moderate, or high. (ACR, 2008)

MEASURE #178 - RHEUMATOID ARTHRITIS (RA): FUNCTIONAL STATUS ASSESSMENT
RATIONALE:
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.

CLINICAL RECOMMENDATION STATEMENTS:
The management of RA is an iterative process, and patients should be periodically reassessed for evidence of disease or limitation of function with significant alteration of joint anatomy. Baseline evaluation of disease activity and damage in patients with rheumatoid arthritis through 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. 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 ESR or CRP level), and mechanical joint problems.

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)

MEASURE #179 - RHEUMATOID ARTHRITIS (RA): ASSESSMENT AND CLASSIFICATION OF DISEASE PROGNOSIS
RATIONALE:
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 decisions.

CLINICAL RECOMMENDATION STATEMENTS:
Poor prognosis is suggested by earlier age at disease onset, high titer of RF, elevated 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, 2008)
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)

MEASURE #180 - RHEUMATOID ARTHRITIS (RA): GLUCOCORTICOID MANAGEMENT
RATIONALE:
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.

CLINICAL RECOMMENDATION STATEMENTS:
Low-dose oral glucocorticoids and local injections of glucocorticoids are highly effective for relieving symptoms in patients with active RA. 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 equal or less than 10 mg of prednisone per day. (ACR, 2002)

**MEASURE #337 - TUBERCULOSIS PREVENTION FOR PSORIASIS, PSORIATIC ARTHRITIS AND RHEUMATOID ARTHRITIS PATIENTS ON A BIOLOGICAL IMMUNE RESPONSE MODIFIER**

**RATIONALE:**
The safety of biologics in terms of their long-term adverse events and their use in different types of psoriasis and in different patient populations is important for clinicians to understand and monitor. Biologics have been associated with a variety of serious and “routine” opportunistic infections, particularly tuberculosis. For this reason, anti-tuberculosis testing both prior to the initiation of a biologic therapy and annually during treatment is pertinent.

**CLINICAL RECOMMENDATION STATEMENTS:**
When planning to initiate treatment of a patient with psoriasis with a biologic it is important to obtain an age appropriate history and physical examination along with an updated medication list. In addition, it is also important to obtain a reliable set of baseline laboratory studies that will allow the clinician to detect and be aware of any underlying conditions or risk factors. This is particularly important because after patients have been initiated on a biologic treatment, they are likely to be treated with other biologics or systemic therapies and it may be useful to have reliable baseline laboratory studies. Tuberculosis testing (PPD) should be performed on all patients who will be treated with TNF inhibitors as there are reports of tuberculosis reactivation in patients treated with this class of drug. (AAD)