Measure #108: Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis

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)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of rheumatoid arthritis will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes can be used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier codes allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

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

Definition: "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

Numerator Coding:
DMARD Prescribed, Dispensed, or Administered
CPT II 4187F: Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered

OR

DMARD not Prescribed, Dispensed, or Administered for Medical Reasons
Append a modifier (1P) to CPT Category II code 4187F to report documented circumstances that appropriately exclude patients from the denominator.

- 1P: Documentation of medical reason(s) for not prescribing, dispensing, or administering disease modifying anti-rheumatic drug therapy

OR

DMARD not Prescribed, Dispensed, or Administered, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4187F to report circumstances when the action described in the numerator is not performed and the reason is no otherwise specified.

- 8P: Disease modifying anti-rheumatic drug therapy was not prescribed, dispensed, or administered, reason not otherwise specified

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis

Denominator Coding:
An ICD-9 diagnosis code for rheumatoid arthritis and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 714.0, 714.1, 714.2, 714.81
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99455, 99456

RATIONALE:
Arthritis and other rheumatic conditions comprise the leading cause of disability among adults in the United States, and the cost of this public health burden is expected to increase as the U.S. population ages. Rheumatoid arthritis (RA) affects 1 percent of the adult population. Although the course of RA in individual patients is highly variable, most patients with persistent RA develop progressive functional limitation and physical disability. In addition, there is excess mortality and decreased survival among patients with persistent RA compared with the general population. While the prevalence of RA is low, the associated costs are very high over the lifetime of the affected person. Costs of RA amount to approximately 1 percent of the U.S. Gross National Product.

RA is a chronic autoimmune disorder often characterized by progressive joint destruction and multi-system involvement. RA affects approximately 2.5 million Americans, disproportionately women. There is no cure; consequently, the goal of treatment is to slow the progression of disease, thereby delaying or preventing joint destruction, relieving pain and maintaining functional capacity. RA pain is often most effectively managed in the long term by altering the natural history of the active progressive disease with DMARDs, but analgesics and anti-inflammatory drugs also have an important place in pain management.

CLINICAL RECOMMENDATION STATEMENTS:
RA should be treated as early as possible with DMARDs to control symptoms and delay disease progression.
Good Practice Point: All patients with persistent inflammatory joint disease (> 6–8 weeks duration) already receiving simple analgesics and NSAIDs should be considered for referral for specialist rheumatology opinion and DMARD therapy, preferably within 12 weeks.
Early DMARD therapy in RA is important to maintain function and reduce later disability.
DMARD therapy should be sustained in inflammatory disease in order to maintain disease suppression.

American College of Rheumatology (ACR) Subcommittee on Rheumatoid Arthritis Guidelines: Guidelines for *the Management of Rheumatoid Arthritis.* The majority of patients with newly diagnosed RA should be started on DMARD therapy within three months of diagnosis. All patients with RA are candidates for DMARD therapy. Although NSAIDs and glucocorticoids may alleviate symptoms, joint damage may continue to occur and progress.
Initiation of DMARD therapy should not be delayed beyond three months for any patient with an established diagnosis who, despite adequate treatment with NSAIDs, has ongoing joint pain, significant morning stiffness or fatigue, active synovitis, persistent elevation of the ESR or CRP level or radiographic joint damage. For any untreated patient with persistent synovitis and joint damage, DMARD treatment should be started promptly to prevent or slow further damage.
(ACR: Wherever possible, guidelines are evidence-based. However, because significant gaps in knowledge still exist, some recommendations are based on best practices and a consensus of the committee.)
American College of Rheumatology Subcommittee of Rheumatoid Arthritis. Guidelines for the Management of Rheumatoid Arthritis: 2002 Update. *Arthritis Rheum.* 2002;46:328-346.

Scottish Intercollegiate Guidelines Network: *Management of Early Rheumatoid Arthritis.*
There is clear evidence from placebo-controlled trials that DMARDs reduce symptoms in RA (as measured by joint pain, swelling and tenderness, and duration and severity of morning stiffness). DMARDs also improve global well being, as assessed by both patients and physicians. It is becoming increasingly clear that DMARDs should be introduced as soon as possible. Protracted benefit may be achieved in RA patients if appropriate DMARD therapy is introduced early.
Refer to Scottish Intercollegiate Guidelines Network. Management of Early Rheumatoid Arthritis, 2000.