Rheumatoid Arthritis (RA) Measures Group

Physician Quality Reporting System Data Collection Sheet*

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	☐ Male ☐ Female
National Provider Identifier (NPI)		Date of Encounter	

Step 1 Preliminary reporting requirements

You must identify your intent to report the RA Measures Group by submitting the G-code specific to this measures group on the first patient claim (G8490: I intend to report the RA Measures Group). You do not need to resubmit the measures group-specific G-code on more than one claim.

Step 2 Determine patient eligibility

*(Codes determining a patient's eligibility must be reported on the **same claim** as the quality code(s) identified in Step 3 below.)*

	Yes	No	
Patient is aged 18 years and older on date of encounter.	☐	☐	Refer to date of birth listed above or on claim form.
Patient has a diagnosis of RA.	☐	☐	714.0, 714.1, 714.2, 714.81
There is a CPT Code for an office visit.	☐	☐	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

If **No** is checked for any of the above, STOP. This patient is not eligible for reporting on this measures group.
Do not report a CPT category II code or G-code.

Step 3 Complete individual measures

Periodic Assessment of Disease Activity	Report one code for assessment/classification of disease activity OR one code for NOT assessed.	
Physician Quality Reporting System Measure #177 • *reporting frequency: a minimum of once during the reporting period* • *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.*	Disease activity assessed and classified as low	☐ 3470F
	Disease activity assessed and classified as moderate	☐ 3471F
	Disease activity assessed and classified as high	☐ 3472F
	OR	
	Disease activity NOT assessed	☐ 3470F–8P

Functional Status Assessment	Report one code for assessment of functional status OR one code for NOT assessed.	
Physician Quality Reporting System Measure #178 • *reporting frequency: a minimum of once during the reporting period* • *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.*	Functional status assessed	☐ 1170F
	OR	
	Functional status NOT assessed	☐ 1170F–8P

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*For additional information on the Physician Quality Reporting System program and reporting on measures groups, please visit the CMS Web site at http://www.cms.hhs.gov/pqri.

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Assessment and Classification of Disease Prognosis	Report one code for assessment/classification of disease prognosis OR one code for NOT assessed.	
Physician Quality Reporting System Measure #179 • *reporting frequency: a minimum of once during the reporting period* • *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.* • *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.*	Disease prognosis assessed and classified as good	☐ 3476F
	Disease prognosis assessed and classified as poor	☐ 3475F
	OR	
	Disease prognosis NOT assessed	☐ 3475F–8P
Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Report one code for DMARD therapy OR one code for DMARD therapy NOT prescribed, dispensed, or administered.	
Physician Quality Reporting System Measure #108 • *reporting frequency: a minimum of once during the reporting period* • *Biologic DMARD Therapy Includes adalimunab, etanercept, infliximab, abatacept, anakinra and rituximab* • *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.*	DMARD therapy prescribed, dispensed, or administered	☐ 4187F
	Not prescribed, dispensed, or administered for medical reasons • Document reason in medical chart	☐ 4187F–1P
	OR	
	DMARD therapy NOT prescribed, dispensed, or administered, reason not otherwise specified	☐ 4187F–8P
Tuberculosis (TB) Screening	Report one code for biologic DMARD therapy status. If patient is receiving a first course of biologic DMARD therapy (excluding rituximab), you will also need to report one code for TB screening performed or one code for TB screening NOT performed.	
Physician Quality Reporting System Measure #176 • *reporting frequency: a minimum of once during the reporting period* • *TB screening must be performed and results interpreted 6 months prior to patient's first course of biologic DMARD therapy* • *Biologic DMARD Therapy Includes adalimunab, etanercept, infliximab, abatacept, anakinra (rituximab is excluded)* • *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*	Patient not receiving a first course of biologic DMARD therapy (or biologic DMARD prescription is for rituximab)	☐ 4196F
	Patient receiving a first course of biologic DMARD therapy AND TB screening performed and results interpreted within 6 months prior to therapy	☐ 4195F AND 3455F
	Patient receiving a first course of biologic DMARD therapy AND TB screening not performed or results not interpreted for medical reasons (ie, patient positive for TB and documentation of past treatment; patient has recently completed a course of anti-TB therapy) • Document reason in medical chart	☐ 4195F and 3455F–1P
	OR	
	Patient receiving a first course of biologic DMARD therapy AND TB screening NOT performed or results NOT interpreted	☐ 4195F and 3455F–8P

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Glucocorticoid Management		Report one code for glucocorticoid use (including dose) assessed or ONE code for glucocorticoid use NOT assessed. If patient is receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months with improvement or no change in disease activity, you will also need to report one code for management plan documented OR one code for management plan NOT documented.	
Physician Quality Reporting System Measure #180 • *reporting frequency: a minimum of once during the reporting period* • *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 antirheumatic drug (DMARD) OR increase in dose of non-glucocorticoid DMARD dose for persistent RA disease activity at current or reduced dose* • *Prolonged dose — Doses > 6 months in duration*	Assessment of glucocorticoid use (including dose) and management plan, if appropriate	Patient not receiving glucocorticoid therapy	☐ 4192F
		Patient receiving < 10 mg daily prednisone (or equivalent) OR glucocorticoid use is for less than 6 months OR RA disease activity is worsening	☐ 4193F
		Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months with improvement or no change in disease activity AND management plan documented	☐ 4194F AND 0540F
		Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months with improvement or no change in disease activity AND management plan not documented for medical reasons (ie, glucocorticoid prescription is for a medical condition other than RA) • Document reason in medical chart	☐ 4194F AND 0540F–1P
		OR *(Report one of the following options)*	
		Glucocorticoid use NOT assessed	☐ 4194F–8P
		Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months with improvement or no change in disease activity AND management plan NOT documented	☐ 4194F AND 0540F–8P

Step 4 Reporting Instructions

This measure can be reported for each eligible patient in one of two ways:

1. Report the corresponding CPT category II code(s) as selected above for each of the six measures in the RA Measures Group

   OR

2. If **all** quality actions for the patient have been performed for each of the six measures in the RA Measures Group, **G8499** may be reported.
   Note: G8499 is not appropriate for this patient if any CPT category II codes with the 8P modifier have been selected from Step 3.