RHEUMATOID ARTHRITIS (RA) MEASURES GROUP OVERVIEW

2014 PQRS OPTIONS FOR MEASURES GROUPS:

2014 PQRS MEASURES IN RHEUMATOID ARTHRITIS (RA) MEASURES GROUP:
#108. Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy
#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

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:** 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, 2014 OR July 1 through December 31, 2014).

- 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-9-CM [for use 1/1/2014 – 9/30/2014]:** 714.0, 714.1, 714.2, 714.81

**ICD-10-CM [for use 10/1/2014 - 12/31/2014]:** 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, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061,
M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

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

- Report a numerator option on all measures within the RA Measures Group for each patient within the eligible professional’s patient sample.

- 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

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

- 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 measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 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 groups option.
Measure #108 (NQF 0054): Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

DESCRIPTION:
Percentage of patients aged 18 years and older who were diagnosed with RA and were prescribed, dispensed, or administered at least one ambulatory prescription for a DMARD

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

Definitions:
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.

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>
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<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, J9260</td>
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<td></td>
<td>Gold sodium thiomalate</td>
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<tr>
<td></td>
<td>Leflunomide</td>
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<tr>
<td></td>
<td>Methotrexate</td>
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<td></td>
<td>Penicillamine</td>
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<tr>
<td>Immnomodulators</td>
<td>Abatacept</td>
<td>J0129, J0135, J0718, J1438, J1745, J3262, J9310</td>
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<tr>
<td></td>
<td>Adalimumab</td>
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<td></td>
<td>Anakinra</td>
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<td>Certolizumab</td>
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<td></td>
<td>Certolizumab pegol</td>
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<td></td>
<td>Etanercept</td>
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<td>Golimumab</td>
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<td>Infliximab</td>
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<td></td>
<td>Rituximab</td>
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<td></td>
<td>Tocilizumab</td>
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<tr>
<td>Immunosuppressive agents</td>
<td>Azathioprine</td>
<td>J7502, J7515, J7516, J7517, J7518</td>
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<td></td>
<td>Cyclosporine</td>
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<tr>
<td></td>
<td>Mycophenolate</td>
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<tr>
<td>Janus kinase (JAK) Inhibitor</td>
<td>Tofacitnib</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:
Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered (4187F)

OR

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

Disease modifying anti-rheumatic drug therapy was not prescribed, dispensed, or administered, reason not otherwise specified (4187F with 8P)
Measure #176: Rheumatoid Arthritis (RA): Tuberculosis Screening

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 NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The “correct combination” of codes may require the submission of multiple numerator codes.

Numerator Options:
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)

OR

Documentation of medical reason for not screening for TB or interpreting results (ie, patient positive for TB and documentation of past treatment; patient 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)

OR

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

OR

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

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 Options:
Rheumatoid arthritis (RA) disease activity, low (3470F)
OR
Rheumatoid arthritis (RA) disease activity, moderate (3471F)
OR
Rheumatoid arthritis (RA) disease activity, high (3472F)
OR
Disease activity not assessed and classified, reason not otherwise specified (3470F with 8P)
**Measure #178: Rheumatoid Arthritis (RA): Functional Status Assessment**

**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:**

- Functional status assessed (1170F)
- Functional status not assessed, reason not otherwise specified (1170F with 8P)
**Measure #179: Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis**

**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 least one of the following: functional limitation (e.g., HAQ Disability Index), extra-articular disease (e.g., vasculitis, Sjögren’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:**
- Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented (3475F)
- Disease prognosis for rheumatoid arthritis assessed, good prognosis documented (3476F)
- Disease prognosis for rheumatoid arthritis not assessed and classified, reason not otherwise specified (3475F with 8P)
**Measure #180: Rheumatoid Arthritis (RA): Glucocorticoid Management**

**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 NOTE:** The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The “correct combination” of codes may require the submission of multiple numerator codes.

**Numerator Options:**
1. Patient not receiving glucocorticoid therapy (4192F)
   OR
2. Patient receiving < 10 mg daily prednisone (or equivalent), or RA disease activity is worsening, or glucocorticoid use is for less than 6 months (4193F)
   OR
   - 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
   - Documentation of medical reason(s) for not documenting glucocorticoid dose and documenting 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
   - Glucocorticoid dose was not documented, reason not otherwise specified (4194F with 8P)
     OR
     - Glucocorticoid 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)
RHEUMATOID ARTHRITIS (RA) MEASURES GROUP RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS

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 #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)