Measure #270: Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Sparing Therapy – National Quality Strategy Domain: Effective Clinical Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease who have been managed by corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills that have been prescribed corticosteroid sparing therapy in the last reporting year

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of inflammatory bowel disease seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 and older with a diagnosis of inflammatory bowel disease

Definition:
Corticosteroids – Prednisone equivalents used expressly for the treatment of IBD and not for other indications (including premedication before anti-TNF therapy, non-IBD indications) can be determined using the following: 1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for inflammatory bowel disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 555.0, 555.1, 555.2, 555.9, 556.0, 556.1, 556.2, 556.3, 556.4, 556.5, 556.6, 556.8, 556.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99346, 99347, 99348, 99349, 99350, 99406, 99407
AND
Patient who has received or is receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills: G9467

NUMERATOR:
Patients managed with corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills AND prescribed a corticosteroid sparing therapy (e.g., thiopurines, methotrexate, or biologic agents)

Numerator Options:
Performance Met: Corticosteroid sparing therapy prescribed (4142F)

OR
Medical Performance Exclusion: Documentation of medical reason(s) for not treating with corticosteroid sparing therapy (eg, benefits of continuing steroid therapy outweigh the risk of continuing steroid therapy or initiating steroid sparing therapy, patient is receiving the first course of corticosteroids for the treatment of IBD) (4142F with 1P)

OR
Patient Performance Exclusion: Documentation of patient reason(s) for not treating with corticosteroid sparing therapy (eg, patient refuses to initiate steroid sparing therapy) (4142F with 2P)

OR
Performance Not Met: Corticosteroid sparing therapy not prescribed, reason not otherwise specified (4142F with 8P)

RATIONALE:
Thirty to forty percent of patients with moderate to severe IBD have steroid dependent disease. That means that they are unable to taper off steroids without experiencing a flare up. (Crohn's and Colitis Foundation of America, Corticosteroids, Special Considerations. www.ccfa.org, Jan. 16, 2009). A retrospective study examined whether the treatment of Crohn's disease (CD) and ulcerative colitis (UC) with immunosuppressant medications was associated with an increased risk of death prior to antitumor necrosis factor therapies. The authors found that patients with both CD and UC are at increased risk of death during periods of current corticosteroid use. In contrast, current treatment with thiopurines was not associated with an increased risk of death. (Lewis J et al. Immunosuppressant Medications and Mortality in Inflammatory Bowel Disease. Am J Gastro.2008; 103:1428-1435).

CLINICAL RECOMMENDATION STATEMENTS:
Long-term treatment with corticosteroids is undesirable. Patients with chronic active corticosteroid-dependent disease (either CD or UC) should be treated with AZA [azathioprine] 2.0 to 3.0 mg/kg/day or 6-MP [6-mercaptopurine] 1.0 to 1.5 mg/kg/day in an effort to lower or preferably eliminate corticosteroid use. Infliximab is another option in this situation, as is combination infliximab/antimetabolite therapy. (Grade A) (American Gastroenterological Association Institute. American Gastroenterological Association Institute Medical Position Statement on Corticosteroids, Immunomodulators, and Infliximab in Inflammatory Bowel Disease. Gastroenterology. 2006;130:935–939.)

Individual patients with either CD or UC who experience a severe flare of disease requiring corticosteroid treatment or require retreatment during the year with another course of corticosteroids should be considered for initiation of therapy with AZA 2.0 to 3.0 mg/kg/day or 6-MP 1.0 to 1.5 mg/kg/day in an effort to avoid future corticosteroid use. Infliximab is another option in this situation, as is combination infliximab/antimetabolite therapy. (Grade C) (American Gastroenterological Association Institute. American Gastroenterological Association Institute Medical Position Statement on Corticosteroids, Immunomodulators, and Infliximab in Inflammatory Bowel Disease. Gastroenterology. 2006;130:935–939.)
Statement on Corticosteroids, Immunomodulators, and Infliximab in Inflammatory Bowel Disease. Gastroenterology. 2006; 130:935–939.)

Conventional corticosteroids are not efficacious in maintenance treatment of patients with CD (Grade A) or patients with UC (Grade B). (American Gastroenterological Association Institute. American Gastroenterological Association Institute Medical Position Statement on Corticosteroids, Immunomodulators, and Infliximab in Inflammatory Bowel Disease. Gastroenterology.2006; 130:935–939.)

Corticosteroids should not be used to maintain remission (EL1a, RG A) (European Crohn’s and Colitis Organization [ECCO, 2006]. European evidence based consensus on the diagnosis and management of Crohn’s disease: current management. Gut. 2006 Mar; 55 Suppl 1:i16-35.)

Conventional corticosteroids should not be used as long-term agents to prevent relapse of CD (Grade A). Budesonide at a dose of 6 mg/day reduces the time to relapse in ileal and/or right colonic disease, but does not provide significant maintenance benefits after 6 months (Grade A). Azathioprine/6-mercaptopurine (Grade B) and methotrexate (Grade B) have demonstrable maintenance benefits after inductive therapy with corticosteroids. (Lichtenstein, GR et al. Management of Crohn’s Disease in Adults. Am J Gastro. 2009.)

This is the first report from the TREAT Registry, a large, prospective, observational research program designed to address the long term safety of medications, including infliximab, for the treatment of CD. After adjustment for confounding factors including disease severity and the use of other medications, the risk for serious infection or death with infliximab use was similar to that observed with the use of conventional immunomodulators, and was not higher than the overall incidence of serious infections among all CD patients.

The use of prednisone was a strong independent risk factor for both serious infection and death. Likewise, the use of narcotic analgesics also was associated with a significantly increased risk for serious infection. (Lichtenstein GR, Feagan BG, Cohen RD, Salzberg BA, Diamond RH, Chen DM, Pritchard ML, Sandborn WJ. Serious infections and mortality in association with therapies for Crohn’s disease: TREAT registry. Clin Gastroenterol Hepatol. 2006 May; ; 4 (5):621-30.)