Measure #274: Inflammatory Bowel Disease (IBD): Testing for Latent Tuberculosis (TB) Before Initiating Anti-TNF (Tumor Necrosis Factor) 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 (IBD) for whom a tuberculosis (TB) screening was performed and results interpreted within 6 months prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy

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:
First Course of anti-TNF therapy – the first (ever) course of anti-TNF therapy

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
Patients receiving a first course of anti-TNF therapy: G8868
NUMERATOR:
Patients who had TB screening performed and results interpreted, within 6 months prior to receiving a first course of anti-TNF therapy

**Numerator Options:**

- **Performance Met:**
  - Documentation that tuberculosis (TB) screening test performed and results interpreted (3510F)

- **OR**
  - **Performance Met:**
    - Patient not receiving a first course of anti-TNF (tumor necrosis factor) therapy (6150F)

- **OR**
  - **Medical Performance Exclusion:**
    - Documentation of medical reason(s) for not performing TB screening test within 6 months prior to receiving a first course of anti-TNF therapy (eg, patient positive for TB and documentation of past treatment; patient recently completed course of anti-TB therapy) (3510F with 1P)

- **OR**
  - **Patient Performance Exclusion:**
    - Documentation of patient reason(s) for not performing TB screening test within 6 months prior to receiving a first course of anti-TNF therapy (eg, patient declined) (3510F with 2P)

- **OR**
  - **Performance Not Met:**
    - TB screening test not performed within 6 months prior to receiving a first course of anti-TNF therapy, reason not otherwise specified (3510F with 8P)

RATIONALE:
Before initiating biologic anti-TNF therapy for a patient with IBD, it is essential to screen the patient for tuberculosis, as research has documented a higher incidence of TB after anti-TNF therapy. All patients being considered for biologic anti-TNF therapy 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.

Opportunity for improvement: While there are a limited number of studies that investigate gaps in care for patients with IBD, the research that does exist identifies opportunities for improvement in care areas: 1) there is a lack of adherence to tuberculosis screening, most noticeably in the use of disease-modifying anti-TNF drugs, and 2) variations in care by practice setting, geographic region and physician specialty.

Golimumab, certolizumab pegol, infliximab and adalimumab may all trigger latent TB. Also, all patients should be monitored during therapy for active TB even if the initial latent TB testing is negative. (See FDA package labeling for these anti-TNF biological agents).

Reactivation of hepatitis B virus has been reported in patients who are carriers of this virus and are taking TNF blocker medicines. (Kaiser T, Moessner J, McHutchison JG, Tillmann HG. Life threatening liver disease during treatment with monoclonal antibodies. BMJ 2009;338:b508.)

CLINICAL RECOMMENDATION STATEMENTS:
Prior to commencing treatment with anti-TNF, all patients should be screened for TB in accordance with the British Thoracic Society (BTS) guidelines. Active TB needs to be adequately treated before anti-TNF therapy can be started. Prior to commencing anti-TNF therapy, consideration of prophylactic anti-TB therapy (as directed by the BTS guidelines) should be given to patients with evidence of potential latent disease (past history of TB treatment or

In an immunocompromised person (adult or child), the tuberculin skin test (TST) should be the initial test used to detect LTBI. If the TST is positive, the person should be considered to have LTBI.

However, in light of the known problem with false-negative TST results in immunocompromised populations, a clinician still concerned about the possibility of LTBI in an immunocompromised person with a negative initial TST result may perform an IGRA test. If the IGRA (interferon-gamma release assay) result is positive, the person might be considered to have LTBI. If the IGRA result is indeterminate, the test should be repeated to rule out laboratory error. If the repeat test is also indeterminate, the clinician should suspect anergy and rely on the person’s history, clinical features, and any other laboratory results to make a decision as to the likelihood of LTBI. Although both IGRA tests may be used as described above, there is evidence that the T-SPOT.TB assay may be more sensitive than the QFT-GIT assay in active TB, and this characteristic might be especially relevant in immunocompromised populations. While the approach of accepting either test result (TST or IGRA) as positive will improve the sensitivity of detecting LTBI in immunocompromised populations, there are no data supporting the efficacy of preventive therapy in TST-negative but IGRA-positive individuals. Thus the ©2010-2011 American Gastroenterological Association. All rights reserved. Page 31 of 52 clinician must weigh the potential benefit of detecting more persons with positive test results against the lack of evidence for the benefit of preventive therapy in such persons. (Canada Communicable Disease Report, October 2008.)