Rheumatoid Arthritis

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the treatment of Rheumatoid Arthritis (RA). The CPG discusses management of RA as well as behavioral health implications. In addition, the CPG outlines the organizations that WellCare aligns with regarding RA and relevant Measureable Health Outcomes.

OVERVIEW

Rheumatoid arthritis (RA) is an autoimmune disorder of unknown etiology characterized by symmetric, erosive synovitis and, in some cases, extra-articular involvement. Most patients experience a chronic fluctuating course of disease that, despite therapy, may result in progressive joint destruction, deformity, disability, and even premature death. RA results in more than 9 million physician visits and more than 250,000 hospitalizations per year. Disability from RA causes major economic loss and can have a profound impact on families. RA affects 1% of the adult population. This low prevalence means that the average physician often develops little experience with its diagnosis or management.

Depending on the health care setting, the majority of the care of patients with RA may be provided by a single physician (primary care physician or rheumatologist who also provides primary care) or the responsibility may be shared. The role of the primary care physician is to recognize and diagnose RA at its onset and to ensure that the patient receives timely treatment before permanent joint damage has occurred. The rheumatologist should provide support and consultation to the patient and his or her primary care physician in the diagnosis and treatment of the RA. Since the level of training and experience in diagnosing and managing RA varies among primary care physicians, the responsibility for accurate diagnosis and monitoring of RA activity and/or drug toxicity may appropriately be assigned to a rheumatologist. If the care of a patient with RA is to be shared, an explicit plan for monitoring RA disease activity and/or drug toxicity needs to be formulated. The patient's preference may be the most important factor in deciding which physician(s) assumes responsibility for care. A general health maintenance strategy should be developed, and responsibility for this strategy should be coordinated among the patient's health care providers. Routine prevention measures, such as screening for hypertension or cancer, should be recommended and risk factors modified.[1]

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the American College of Rheumatology (ACR) and the National Institute for Health Care Excellence (NICE). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to RA, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);

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- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the ACR and NICE on the topic of RA. Highlights from their publications are noted below.

AMERICAN COLLEGE OF RHEUMATOLOGY (ACR)

The American College of Rheumatology (ACR) has published the *2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis.* Highlights are presented below, including recommendations for patients with early RA, established RA, and high-risk comorbidities. The ACR guideline can be viewed here.[1]

NATIONAL INSTITUTE FOR HEALTH CARE EXCELLENCE (NICE)

The National Institute for Health Care Excellence (NICE) published the guideline *Rheumatoid Arthritis in Adults: Management.* The guideline provides recommendations on:

- Referral, Diagnosis and Investigations
- Communication and Education
- Multidisciplinary Team
- Pharmacological Management
- Monitoring
- Timing and Referral for Surgery
- Diet and Complementary Therapies

The NICE guideline can be viewed here.[2]

Evidence Based Practice

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) has published the following report(s):

- **Drug Therapy for Rheumatoid Arthritis** [3] (click here)
  The objective of the report is to provide a comparison of the benefits and harms of corticosteroids, oral and biologic disease-modifying antirheumatic drugs (DMARDs) for adults with rheumatoid arthritis.

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Quality Improvement.*

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

Care Management

The goals for Care Management are to support the member's ability to self-manage their disease, minimize risks associated with Rheumatoid Arthritis, and remove barriers preventing them from achieving those goals. Integrated Care Management:

- Ensure member has a specialist who can provide medications that adequately manage their disease and pain, evaluate laboratory data, assess response to treatments and determine need for surgerical intervention
- Ensure member's understanding of medication dosing and adherence to medications, refilling timely
- Provide assistance with functional status and ADLs (e.g. DME, therapies)
- Provide education on ways to manage their disease (e.g. non-pharmacological pain strategies, ways to combat fatigue and reduction of fall risks)
- Assess for risk of depression and share with appropriate provider(s) if risks are identified

MEASURABLE HEALTH OUTCOMES

Targeted Health Outcomes (Extended Program Goals) result from successful member self-management (see Case Management Objectives).

1. The Member experiences a reduction in pain scores with adherence to medication regimen and therapies at 6-12 months post engagement. In absence of documentation, Provider and/or Member narrative/HRA data used.
2. The Member experiences an increase in ability to complete ADLs at 6-12 months post engagement.
3. Adherence to medication regimen, when appropriate, as evidenced by pharmacy claims pre and post engagement at 6-12 months. In absence of documentation, Provider and/Member narrative/HRA data used.

CASE MANAGEMENT GOALS

Case Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which will lead to the targeted health outcomes above. Examples:

- Member will obtain and attend Rheumatology (or PCP) appointments as scheduled by provider within 60 days
- Member will be adherent to medication regimen as evidenced by pharmacy claims over last 30 days
- Member will be able to increase functional activity levels by 5 minutes each week over the next 30 days
- Member will be able to complete specific ADLs with the assistance of DME within 60 days
- Member will verbalize 3 non-pharmacological pain relief techniques and utilize these as needed for pain control over the next 60 days
- Specific for Members requiring hospitalization: The Member participates in provider follow-up visit within 7 days of hospital discharge

CASE MANAGEMENT OBJECTIVES

Case Management Objectives should focus on improving the Member's self-management skills up including:

- Addressing barriers to medication adherence
- Assisting with scheduling provider appointments or obtaining specialist referrals
- Providing education on non-pharmacological pain relief techniques
- Providing education on disease process
- Assisting with coordination of needed DME
- Conduct screening for anxiety/depression as appropriate

MEDICAL BEHAVIORAL INTEGRATION

Studies have shown that those with arthritis, particularly rheumatoid arthritis and osteoarthritis, had a much higher rate of psychiatric disorders than those with other chronic illnesses. This link may be explained by the fact that those with arthritis have more functioning limitations than those with other diseases, and the loss of ability may lead to low self-esteem, loss of identity and depression. Depression may also worsen health outcomes of patients already diagnosed with arthritis by affecting inflammation, interfering with functioning and reducing adherence.[5] Stress may also contribute to problems regulating autoimmune responses which may cause or aggravate RA. Some studies also show that patients with depression and RA have greater rates of pain than those without depression.[6]

MEMBER EDUCATIONAL RESOURCES

Currently there are no Krames/StayWell Member educational materials utilized by WellCare Case Managers.

PHARMACOLOGY

A listing is provided below of common drugs used to treat RA. In addition to items noted in the Guideline Hierarchy from the ACR and NICE, please access the Preferred Drug List (PDL) and directions on how to submit a request, visit www.wellcare.com and select the applicable state. From there, visit the Provider section where you will find the PDL and related Pharmacy items.

The following categories of medications may be prescribed:

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- 5-Aminosalicylates (Sulfasalazine, Guaidenesin-theophylline)
- Alkylating agents (Cyclophosphamide)
- Aminoquinolines (Hydroxychloroquine)
- Anti-rheumatics (Auranofin, Gold sodium thiomalate, Leflunomide, Methotrexate, Penicillamine)
- Immunomodulators (Abatacept, Adalimumab, Anakinra, Certolizumab, Certolizumab pegol, Etanercept, Golimumab, Infliximab, Rituximab, Tocilizumab)
- Immunosuppressive Agents (Azathioprine, Cyclosporine, Mycophenolate)
- Janus Kinase Inhibitor (JAK) (Tofacitinib)
- Tetracyclines (Minocycline)

Additional information regarding pharmacological agents are included below:

Non-Steroidal anti-inflammatory drugs (NSAIDs). A group of medications that relieve pain and inflammation if taken regularly (e.g., aspirin, ibuprofen, ketoprofen, naproxen sodium). NSAIDs are available by prescription and include stronger doses of ketoprofen, naproxen and ibuprofen as well as tolmetin, diclofenac, nabumetone and indomethacin.

COX-2 inhibitors. This class of NSAIDs may be less damaging to the stomach. Like other NSAIDs, COX-2 inhibitors, like celecoxib, suppress an enzyme called cyclooxygenase (COX) that is active in joint inflammation. Other types of NSAIDs work against two versions of the COX enzyme that is present in your body: COX-1 and COX-2. Evidence suggests that by suppressing COX-1, NSAIDs may cause stomach and other problems because COX-1 is the enzyme that protects the stomach lining. Unlike other NSAIDs, COX-2 inhibitors suppress only COX-2.

Corticosteroids. Medications such as prednisone and methylprednisolone can reduce inflammation and pain as well as slow joint damage. Short term, corticosteroids can make the patient feel dramatically better but when used for many months or years, they are less effective and cause serious side effects.

Disease-modifying anti-rheumatic drugs (DMARDs). Physicians prescribe DMARDs to limit the amount of joint damage that occurs with rheumatoid arthritis. Taking these drugs early in the development of RA is especially important in the effort to slow the disease and save the joints and other tissues from permanent damage. The drugs act slowly and it may take weeks to months before benefits are noticed. DMARDs typically are used with an NSAID or a corticosteroid. While the NSAID or corticosteroid addresses immediate symptoms and limits inflammation, the DMARD works on the disease itself. Common DMARDs include hydroxychloroquine, the gold compound auranofin, sulfasalazine and minocycline; other forms include immunosuppressants and tumor necrosis factor (TNF) blockers.

Immunosuppressants. These medications act to tame the body's immune system as well as attack and eliminate cells associated with the disease. Common immunosuppressants include methotrexate, leflunomide, azathioprine, cyclosporine and cyclophosphamide. Side effects can be serious, including and increased susceptibility to infection.

Tumor Necrosis Factor (TNF) blockers. This class of DMARDs is known as biologic response modifiers. TNF is a cytokine, or cell protein, that acts as an inflammatory agent in rheumatoid arthritis. TNF blockers, or anti-TNF medications, target or block this cytokine and can help reduce pain, morning stiffness and tender or swollen joints — usually within one or two weeks after treatment begins. Evidence shows that TNF blockers may halt progression of disease. They are often taken with the immunosuppressant methotrexate. TNF blockers approved for treatment of rheumatoid arthritis are golimumab, etanercept, infliximab and adalimumab. Do not use when active infection present.

Interleukin-1 receptor antagonist (IL-1Ra). IL-1Ra is a biologic response modifier. Interleukin-1 (IL-1) is a cell protein that promotes inflammation; large amounts are found in people who have rheumatoid arthritis or other types of inflammatory arthritis. If IL-1 is prevented from binding to its receptor, the inflammatory response decreases. Anakinra is the first IL-1Ra approved by the FDA for use in people with moderate to severe RA who have not responded adequately to conventional DMARD therapy. It can be used alone or in combination with methotrexate. Anakinra is given as a daily self-administered injection under the skin and should not be used if you have an active infection.

NON-PHARMACOLOGY TREATMENT

Optimal management of RA involves more than pharmacologic therapy. Rheumatologists, other physicians, and their office staff play important roles in educating the patient and the patient’s family about the disease and providing

longitudinal supportive care. The Arthritis Foundation is also an important source of educational material and/or programs. Non-pharmacologic treatments of RA included (but are not limited to):[1]

- Instruction in joint protection
- Conservation of energy
- Home program of joint range of motion and strengthening exercises
- Physical and occupational therapy (may help patients with compromised activities of daily living)
- Regular participation in dynamic and even aerobic conditioning exercise programs (can improve joint mobility, muscle strength, aerobic fitness and function and psychological well-being)
- Psychological counseling (may benefit those struggling as they adjust to living with a chronic disease)

Related WellCare Guidelines

Due to the number of co-morbidities associated with RA, please reference WellCare's catalog of CPGs.

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

References

1. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. American College of Rheumatology Web site. https://www.rheumatology.org/Practice-Quality/Clinical-Support/Clinical-Practice-Guidelines/Rheumatoid-Arthritis. Published 2015. Accessed June 28, 2018.
2. Rheumatoid arthritis in adults: management. National Institute for Health Care Excellence (NICE) Web site. https://www.nice.org.uk/guidance/cg79. Published December 2015. Accessed June 28, 2018.
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5. Nicassio, Perry M. "Arthritis and Psychiatric Disorders: Disentangling the Relationship." *Journal of psychosomatic research* 68.2 (2010): 183–185. *PMC*. Web. 17 Aug. 2017.
6. Irwin, Michael & Davis, Mary. Behavioral Comorbidities in Rheumatoid Arthritis. August 01, 2008. Psychiatric Times. http://www.psychiatrictimes.com/articles/behavioral-comorbidities-rheumatoid-arthritis. Accessed June 28, 2018.

Disclaimer

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
7/12/2018	• Approved by MPC. No changes.
8/18/2017	• Approved by MPC. Inclusion Care Management section and updated HEDIS related items.
11/6/2014	• Approved by MPC. Inclusion of CMS STAR and NCQA HEDIS measures.
11/1/2012	• Approved by MPC. No changes.
12/1/2011	• New template design approved by MPC.
12/2010	• New. Approved by MPC.

Addendum

Assessment of Disease Activity[1]

At each visit, evaluate for subjective and objective evidence of active disease:

- Degree of joint pain (by visual analog scale)

- Duration of morning stiffness
- Duration of fatigue
- Presence of actively inflamed joints on examination (tender and swollen joint counts)
- Limitation of function

Periodically evaluate for disease activity or disease progression:

- Evidence of disease progression on physical examination (loss of motion, instability, malalignment, and/or deformity)
- Erythrocyte sedimentation rate or C-reactive protein elevation
- Progression of radiographic damage of involved joints

Other parameters for assessing response to treatment (outcome):

- Physician's global assessment of disease activity
- Patient's global assessment of disease activity
- Functional status or quality of life assessment using standardized questionnaires (see below)

Instruments Used to Measure Rheumatoid Arthritis Disease Activity[4]

		Thresholds of Disease Activity			
Instrument	**Score Range**	**Remission**	**Low Activity**	**Moderate Activity**	**High Activity**
Patient Activity Scale (PAS) or PAS-II	0 – 10.0	0 – 0.25	0.26 – 3.7	3.71 - < 8.0	≥ 8.0
Routine Assessment Patient Index Data	0 – 10.0	0 – 1.0	> 1.0 – 2.0	> 2.0 – 4.0	> 4.0 – 10
Clinical Disease Activity Index	0 – 76.0	≤ 2.8	>2.8 – 10.0	> 10 – 22	> 22
Disease Activity Score in 28 Joints	0 – 9.4	< 2.6	≥ 2.6 – < 3.2	≥ 3.2 – ≤ 5.1	> 5.1
Simplified Disease Activity Index	0 – 86.0	≤ 3.3	> 3.3 – ≤ 11.0	> 11.0 – ≤ 26	> 26

Surgical Treatment of RA[1]

Surgical procedures should be considered for patients with unacceptable levels of pain, loss of range of motion, or limitation of function because of structural joint damage. Procedures for RA include (but are not limited to): carpal tunnel release; synovectomy; resection of the metatarsal heads; total joint arthroplasty; and joint fusion. New prosthetic materials and cements for fixing joint prostheses have greatly advanced the prevention of aseptic loosening and have increased the longevity of total joint prostheses in patients with RA. Preoperative functional status is an important determinant of the rate of recovery of functional independence after surgery. Strategies for increasing functional recovery include optimization of preoperative functional status and early surgical intervention. The pre- and postoperative team should include health care professionals who have performed large numbers of the particular surgical procedure and are experienced in the care of patients with RA.

Goals of RA Management and Evaluation of RA[1]

The goals of managing RA include prevention or control of joint damage and loss of function, as well as decrease pain. Initial steps in the management of RA include establishing the diagnosis, performing a baseline evaluation, and estimate the prognosis. The initial baseline evaluation of a member with RA should include:

1) Subjective Evaluation

- Document symptoms of active disease (e.g., presence of joint pain and morning stiffness, degree of fatigue)
- Assess limitation of function

2) Objective Physical Examination (including assessment of the following):

- Actively inflamed joints (synovitis as assessed by tender and swollen joint counts and the ESR and CRP level)
- Mechanical joint problems including loss of motion, crepitus, instability, malalignment, and/or deformity

- Presence of extraarticular disease
- Presence of radiographic damage to selected involved joints
- Presence of co-morbid conditions

3) Baseline laboratory assessments including:

- Measurement of erythrocyte sedimentation rate (ESR)/C-reactive protein (CRP)
- Rheumatoid factor (RF) measurement [a]
- Complete blood cell count with white blood cell differential and platelet counts [b]
- Electrolyte levels [b]
- Creatinine levels [b]
- Hepatic enzyme levels (AST, ALT, and albumin) [b]
- Urinalysis [b]
- Stool guaiac [b]
- Synovial fluid analysis [c]

[a] Performed only at baseline to establish the diagnosis. If initially negative, may be repeated 6-12 months after disease onset
[b] Performed at baseline, before starting medications, to assess organ dysfunction due to co-morbid diseases
[c] Performed at baseline, if necessary, to rule out other diseases. May be repeated during disease flares to rule out septic arthritis

4) Other assessment including:

- Functional status or quality of life assessments using standardized questionnaires like the Arthritis Impact
- Measurement Scales or the Health Assessment Questionnaire
- Physician's global assessment of disease activity
- Member's global assessment of disease activity