AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Rheumatoid Arthritis

Quick Reference Guide

2026

1 CLINICAL SNAPSHOT

Definition: Rheumatoid arthritis (RA) is a chronic, systemic autoimmune disease characterized by persistent inflammatory synovitis that leads to progressive joint destruction, functional disability, and increased mortality.[1,2] The disease arises from immune dysregulation involving T cells, B cells, macrophages, and pro-inflammatory cytokines (TNF-α, IL-6, IL-1), triggered in genetically susceptible individuals (HLA-DRB1 shared epitope) by environmental factors including smoking and periodontal disease.[1,3]

ICD-10 Codes: M05.x (seropositive RA, including Felty's syndrome M05.0x, rheumatoid lung disease M05.1x, vasculitis M05.2x, heart disease M05.3x, myopathy M05.4x, polyneuropathy M05.5x, other organ involvement M05.6x, RF-positive without organ involvement M05.7x); **M06.x** (other RA, including seronegative M06.0x, adult-onset Still's disease M06.1, rheumatoid bursitis M06.2x, rheumatoid nodule M06.3x, inflammatory polyarthropathy M06.4, other specified M06.8x). **M06.9** (RA, unspecified) accounts for a substantial proportion of RA diagnoses (estimated 40–55%)[4]— avoid when specificity is available. Site specificity is coded at the 5th–6th character level (.x suffix denotes expandable families).[3–5]

HCC/RAF V28 Mapping

DIAGNOSIS CATEGORY	ICD-10 SERIES	V28 HCC	RAF VALUE	CLINICAL DOCUMENTATION REQUIREMENT
Seropositive RA & other specified inflammatory rheumatic disorders	M05.x (all), M06.0x, M06.1, M06.2x, M06.3x, M06.8x, M06.9	HCC 93	~0.617	Active diagnosis (not "history of"); serostatus; site specificity; manifestations; disease activity state
Inflammatory polyarthropathy	M06.4	HCC 93	~0.617	Only if M06.4 (inflammatory polyarthropathy) is documented; distinct from RA-specific codes

ABBREVIATIONS: HCC = Hierarchical Condition Category; RA = rheumatoid arthritis; RAF = Risk Adjustment Factor; V28 = CMS-HCC model version 28

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2024 CMS-HCC model; values vary across patient populations based on eligibility and care setting.

Annual Value Callout (V28, $10,402.34 MA Rate,(actual MA rates vary by plan and county):

HCC 93 (RA/Specified Inflammatory) ~$6,418.24/yr — HCC 93 · RAF ~0.617

HCC 93 (Inflammatory Polyarthropathy) ~$6418.24/yr — HCC 93 · RAF ~0.617

Prevalence (U.S.)

Approximately **1.3 million U.S. adults** have RA (~0.5–0.6% of the adult population, age-adjusted).[1] Women are affected 2–3 times more frequently than men. Peak incidence occurs at ages 65–69 years (~35 per 100,000).[1] In the **Medicare population (≥65 years)**, approximately 2% of older adults have diagnosed RA; mean age 75.2 years, 79.4% female.[1] Medicare RA patient total annual cost: **$20,919** (vs. $7,197 non-RA controls); RA-attributable cost: **~$9,662 PMPY** (adjusted).[1] Biologic DMARD users: mean annual direct cost **$36,053**.

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings

Note: Medicare does not have RA-specific screening policies. Coverage is based on medical necessity for diagnosis and monitoring.[6]

TEST	COVERAGE	FREQUENCY	CPT CODE	WHAT IT MEASURES
RF + Anti-CCP antibodies	Covered under medical necessity	At diagnosis; repeat if serostatus uncertain	86431 (RF qual), 86200 (anti-CCP)	Serostatus classification; prognostic value for erosive disease
ESR/CRP	Covered	At diagnosis; q1–3 months during active management	85652 (ESR), 86140/86141 (CRP)	Acute-phase inflammatory markers; disease activity monitoring
CBC + CMP	Covered	Baseline; q4–12 weeks on MTX; q3–6 months on biologics	85025 (CBC), 80053 (CMP)	DMARD safety monitoring (hepatotoxicity, cytopenias)
Hand/wrist radiographs	Covered when clinically indicated	At baseline; repeat if disease progression suspected	73110 (bilateral hands)	Baseline erosive disease assessment
Hepatitis B screening	Covered before DMARD/biologic initiation	Once prior to immunosuppression	87340, 87341, 86704, 86706	Required before biologic therapy; reactivation risk
Annual wellness visit	Universal for Medicare beneficiaries	Annual	G0438 (initial), G0439 (subsequent)	Opportunity for RA disease activity assessment and comorbidity screening

ABBREVIATIONS: anti-CCP = anti-cyclic citrullinated peptide; CBC = complete blood count; CMP = comprehensive metabolic panel; CRP = C-reactive protein; DMARD = disease-modifying antirheumatic drug; ESR = erythrocyte sedimentation rate; MTX = methotrexate; RA = rheumatoid arthritis; RF = rheumatoid factor

Subtle Early Signs in Adults ≥65 yrs[1,7,8]

- ***Morning stiffness lasting >30 minutes*** *→ Distinguish from osteoarthritis (typically <30 min); symmetrical involvement of MCP/PIP joints is characteristic of inflammatory arthritis*
- ***New bilateral hand/wrist swelling*** *→ Symmetric small-joint synovitis in an older adult warrants RF/anti-CCP testing even without classic presentation*
- ***Unexplained fatigue with elevated inflammatory markers*** *→ Fatigue attributed to aging with incidentally elevated ESR/CRP; evaluate for systemic inflammatory disease*
- ***Progressive grip weakness without neurologic explanation*** *→ MCP/wrist synovitis causes functional loss before radiographic erosions are visible*
- ***Dry eyes/dry mouth (sicca symptoms)*** *→ Secondary Sjögren syndrome occurs in ~10–15% of RA patients; often precedes or accompanies joint symptoms*
- ***Subcutaneous nodules*** *→ Rheumatoid nodules (present in ~20–30% of seropositive RA) on extensor surfaces suggest established disease*
- ***New-onset carpal tunnel syndrome*** *→ Wrist tenosynovitis from RA can cause median nerve compression; check for synovitis*

Risk Factors[9]

FACTOR	RISK SIGNALS	EVIDENCE SUMMARY	CLINICAL IMPLICATION
Age ≥65	Peak incidence 65–69 yrs (~35/100,000)	Elderly-onset RA (EORA) has distinct features: equal sex ratio, more large-joint involvement, higher acute-phase reactants	Screen for RA in older adults with new symmetric polyarthritis; do not attribute to "just aging"
Female sex	2–3× higher prevalence in women	Hormonal influences on autoimmunity; estrogen withdrawal post-menopause associated with disease onset	Maintain high clinical suspicion in postmenopausal women with new inflammatory joint symptoms
Smoking history	1.5–2× increased risk; dose-dependent	Smoking triggers citrullination of proteins, promoting anti-CCP antibody formation in genetically susceptible individuals	Document smoking status; counseling supports both RA and CV risk reduction
Family history of RA	3–5× increased risk in first-degree relatives	HLA-DRB1 shared epitope alleles account for ~40% of genetic risk	Lower threshold for serologic testing when family history is positive
Cardiovascular disease	2-fold increased MI risk in RA	Chronic inflammation accelerates atherosclerosis; RA confers CV risk comparable to diabetes	Proactive CV risk assessment; statin consideration; BP control
Polypharmacy (≥5 meds)	Increased drug interactions and adverse events	74.5% of geriatric RA patients on corticosteroids; NSAIDs increase GI, renal, and CV risk	Reconcile medications at each visit; minimize NSAID/steroid exposure; document rationale

ABBREVIATIONS: anti-CCP = anti-cyclic citrullinated peptide; CV = cardiovascular; EORA = elderly-onset rheumatoid arthritis; MI = myocardial infarction; NSAID = nonsteroidal anti-inflammatory drug; RA = rheumatoid arthritis

Red Flags — Urgent Action[10,11]

- ***Atlantoaxial instability/subluxation:*** *Neck pain with neurologic symptoms (myelopathy, paresthesias, gait disturbance, bowel/bladder dysfunction) → Immediate neurosurgical consultation; avoid neck manipulation*
- ***Septic arthritis in an RA joint:*** *Acute monoarticular pain/swelling with fever in a patient on immunosuppression → Urgent joint aspiration, blood cultures, hold immunosuppressive therapy*
- ***Rheumatoid vasculitis:*** *Digital ischemia, palpable purpura, mononeuritis multiplex, mesenteric ischemia → Immediate rheumatology consultation; high-dose corticosteroids*
- ***Acute interstitial lung disease exacerbation:*** *Progressive dyspnea, hypoxia, new infiltrates → Urgent pulmonary evaluation; hold methotrexate/leflunomide*
- ***Methotrexate toxicity:*** *Pancytopenia, mucositis, hepatotoxicity → Hold MTX, check CBC/CMP, consider leucovorin rescue*
- **Tachycardia / Hypotension:** Signs of septic shock; exacerbated by steroid use → Immediate ER transfer; initiate IV fluids and broad-spectrum antibiotics
- **New Localized Pain/Redness:** Potential Cellulitis or Septic Arthritis → Physical exam of the "hot joint"; prioritize aspiration to rule out infection
- **Stop the Biologic**: Fever >100.4°F, are taking antibiotics, or have an open/infected wound → Contact doctor
- **Vaccination Vigilance:** Caution receiving a "Live" vaccine (like the yellow fever vaccine) while on a biologic → Ensure all "Inactivated" vaccines (Flu, Pneumonia) are up to date
- ***Severe disease flare with CRP >10 mg/L:*** *Polyarticular flare with constitutional symptoms, inability to perform ADLs → Same-day or next-day rheumatology evaluation*[26]

Diagnostic Thresholds

2010 ACR/EULAR Classification Criteria: Sensitivity 82%, specificity 61%. Requires ≥1 clinically swollen joint and ≥6 points.[1,12,13]

TEST	DIAGNOSTIC VALUE	NOTES
RF (rheumatoid factor)	Low positive: ≤3× ULN = 2 pts; High positive: >3× ULN = 3 pts	Present in ~70–80% of RA; also seen in infections, other autoimmune diseases, and aging
Anti-CCP antibodies	Low positive: ≤3× ULN = 2 pts; High positive: >3× ULN = 3 pts	More specific (~95%) than RF; predicts erosive disease; can precede symptoms by years
ESR	Abnormal ESR = 1 pt	Non-specific; elevated in infection, malignancy, aging; use in combination with CRP
CRP	Abnormal CRP = 1 pt	More responsive than ESR to acute inflammatory changes; useful for monitoring disease activity
Joint distribution score	1 large joint = 0 pts; 2–10 large joints = 1 pt; 1–3 small joints = 2 pts; 4–10 small joints = 3 pts; >10 joints (at least 1 small) = 5 pts	Small joints: MCP, PIP, 2nd–5th MTP, thumb IP, wrists
Symptom duration	≥6 weeks = 1 pt	Persistent synovitis distinguishes RA from viral or reactive arthritis

ABBREVIATIONS: ACR = American College of Rheumatology; anti-CCP = anti-cyclic citrullinated peptide; CRP = C-reactive protein; ESR = erythrocyte sedimentation rate; EULAR = European League Against Rheumatism; MCP = metacarpophalangeal; MTP = metatarsophalangeal; PIP = proximal interphalangeal; RF = rheumatoid factor; ULN = upper limit of normal

Clues to Dig Deeper[8]

- ***Persistently elevated ESR/CRP without clear infectious source:*** *Evaluate for inflammatory arthritis even if joint symptoms are mild; systemic inflammation may precede clinically apparent synovitis*
- ***Symmetric joint stiffness improving with activity:*** *Inflammatory pattern (improves with use) vs. mechanical pattern (worsens with use); consider RA if pattern is inflammatory*
- ***Positive anti-CCP in a patient with undifferentiated arthritis:*** *Anti-CCP is highly predictive of progression to RA; initiate DMARD discussion with rheumatology*
- ***Unexplained normocytic anemia:*** *Anemia of chronic disease is common in active RA; evaluate disease activity and consider iron studies*
- ***New dry cough or exertional dyspnea in a known RA patient:*** *Screen for ILD with pulmonary function tests and high-resolution CT; affects 30–40% of RA patients*

Common Clinical Oversights[14–16]

- **Failing to provide specific DMARD/Biologic instructions before surgery →**The Correction: Follow the 2022 ACR/AAHKS guidelines: Continue csDMARDs (Methotrexate, Sulfasalazine, Hydroxychloroquine). Withhold biologics and JAK inhibitors (typically 1 week prior to surgery, restarting once wound healing is confirmed, usually at 14 days)
- ***Documenting "RA on therapy" without disease activity state →*** *Record a validated disease activity measure (CDAI preferred) and category (remission/low/moderate/high) at each encounter*
- **The Safety Guardrail: Infection & Frailty→** Overlooking the 2-fold baseline infection risk in elderly or frail patients on biologics.
- ***Treating RA in isolation from cardiovascular risk →*** *RA carries CV risk comparable to diabetes; integrate lipid screening, statin consideration, and BP control into RA care*
- ***Overlooking infection risk in elderly patients on biologics →*** *Document infection screening (TB, hepatitis B) and vaccination status; 2-fold increased baseline infection risk*
- ***Missing perioperative DMARD management →*** *Continue csDMARDs through surgery; withhold biologics and JAK inhibitors per 2022 ACR/AAHKS guideline*

Key Differentials[2]

CATEGORY	CLINICAL FINDINGS/TEST	RHEUMATOID ARTHRITIS	PRIMARY DIFFERENTIAL
Joint pattern	Symmetric small-joint polyarthritis	MCP, PIP, wrist involvement; morning stiffness >30 min	OA (asymmetric DIP), psoriatic arthritis (DIP, dactylitis), gout (monoarticular, podagra)
Serology	RF and/or anti-CCP positive	RF sensitivity ~70–80%; anti-CCP specificity ~95%	SLE (ANA+, anti-dsDNA), viral arthritis (parvovirus B19), crystalline arthropathy (synovial fluid crystals)
Imaging	Radiographic erosions or ultrasound synovitis	Marginal erosions at MCP/PIP; US: synovial hypertrophy with Doppler signal	Erosive OA (central erosions), CPPD (chondrocalcinosis), psoriatic arthritis (pencil-in-cup)
Acute presentation	Monoarticular hot, swollen joint in a patient with RA	Flare vs. infection; aspiration required	Septic arthritis, gout, pseudogout (always aspirate to rule out infection in immunosuppressed patients)

ABBREVIATIONS: ANA = antinuclear antibody; anti-CCP = anti-cyclic citrullinated peptide; CPPD = calcium pyrophosphate deposition; DIP = distal interphalangeal; MCP = metacarpophalangeal; OA = osteoarthritis; PIP = proximal interphalangeal; RA = rheumatoid arthritis; RF = rheumatoid factor; SLE = systemic lupus erythematosus; US = ultrasound

Comorbidity Screening[17,18]

CONDITION	APPROX. PREVALENCE	SCREENING	NOTES
Cardiovascular disease	2-fold increased MI risk; leading cause of death in RA	Lipid panel, BP, smoking status at diagnosis and annually	RA confers CV risk comparable to diabetes; statin consideration per ACC/AHA guidelines
Osteoporosis	64.9% in geriatric RA patients	Baseline DEXA; repeat per guidelines or if on glucocorticoids	Steroid-induced bone loss; calcium/vitamin D supplementation; bisphosphonates for high-risk patients
Interstitial lung disease	5–40% of RA patients	Baseline CXR; PFTs if symptomatic; HRCT if ILD suspected	Can be disease-related or DMARD-induced (MTX, LEF); associated with increased mortality
Depression	~18% prevalence	PHQ-9 annually	Bidirectional relationship with disease activity; affects treatment adherence
Diabetes mellitus	33.6% in geriatric RA	A1c at baseline if on steroids; monitor glucose during steroid courses	Glucocorticoid-induced hyperglycemia; 74.5% of geriatric RA patients on steroids
Chronic kidney disease	Elevated in elderly RA	BMP/CMP at baseline and with DMARD monitoring	Dose-adjust MTX and LEF; avoid NSAIDs in impaired renal function

ABBREVIATIONS: A1c = hemoglobin A1c; BP = blood pressure; CKD = chronic kidney disease; CXR = chest X-ray; DEXA = dual-energy X-ray absorptiometry; DMARD = disease-modifying antirheumatic drug; HRCT = high-resolution computed tomography; ILD = interstitial lung disease; LEF = leflunomide; MI = myocardial infarction; MTX = methotrexate; NSAID = nonsteroidal anti-inflammatory drug; PFT = pulmonary function test; RA = rheumatoid arthritis

Disease Activity Classification by Frailty Status

ACR 2019 Recommended Disease Activity Measures, stratified by patient frailty status.[19]

The CDAI is an ACR-validated measure of RA disease activity calculated by summing four components: swollen joint count (28 joints), tender joint count (28 joints), patient global assessment, and evaluator global assessment (range: 0–76). Thresholds: **Remission** ≤2.8 · **Low** ≤10 · **Moderate** ≤22 · **High** >22.

High CDAI scores correlate with increased frailty risk. Frailty status is defined by **Fried's Phenotype** across five components — weight loss, exhaustion, weakness, slow walking speed, and low physical activity — with **Robust** = 0, **Pre-frail** = 1–2, and **Frail** = 3–5 components present.

DISEASE ACTIVITY MEASURE (CDAI)	CDAI SCORE RANGE	ROBUST	PRE-FRAIL	FRAIL
Remission	≤2.8	Standard treat-to-target; taper if sustained remission	Monitor for medication adverse effects; consider cautious taper	Weigh infection risk vs. disease control; prioritize functional preservation
Low	≤10	Continue current regimen; reassess q3–6 months	Adjust for comorbidities; avoid aggressive escalation if stable	Minimize polypharmacy; lowest effective steroid dose; fall risk assessment
Moderate	≤22	Escalate per ACR 2021 guideline; consider adding bDMARD/tsDMARD	Escalate with caution; infection screening; DEXA if steroid escalation	Shared decision-making; weigh functional decline vs. treatment risk; OT/PT referral
High	>22	Aggressive escalation; rheumatology co-management	Prioritize infection prevention; avoid JAK inhibitors if CV risk factors	Individualized goals; comfort and function; minimize hospitalization risk

ABBREVIATIONS: bDMARD = biologic disease-modifying antirheumatic drug; CDAI = Clinical Disease Activity Index; CV = cardiovascular; DEXA = dual-energy X-ray absorptiometry; JAK = Janus kinase; OT = occupational therapy; PT = physical therapy; tsDMARD = targeted synthetic disease-modifying antirheumatic drug

3 MEAT DOCUMENTATION ESSENTIALS

A 54-year-old female elementary teacher was diagnosed with Seropositive Rheumatoid Arthritis 12 months ago. She has been adherent to Methotrexate (MTX) for 4 months but presents today with a significant "flare" and functional decline.[1,8,19]

MONITOR: "RF 187 IU/mL (positive), anti-CCP >250 U/mL (high positive), ESR 42 mm/hr (elevated from 28 in [date]), CRP 2.8 mg/dL (up from 1.1 in [date]). CDAI score 18 (moderate disease activity, increased from 9 at last visit). Patient reports 3 weeks of worsening bilateral hand stiffness lasting 90 minutes each morning, new fatigue, and 2 missed workdays. Tender joint count: 6/28; swollen joint count: 4/28."

EVALUATE: "Hand radiographs ([date]): new marginal erosion at left 3rd MCP compared to baseline films from [date]. No cervical spine instability on flexion/extension views. Physical exam: symmetric synovitis bilateral MCP 2–4, bilateral wrists, left PIP 3. No subcutaneous nodules. No signs of extra-articular manifestations (lungs clear, no vasculitic skin changes). HAQ score 1.25 (mild-to-moderate functional impairment)."

ASSESS: "Seropositive rheumatoid arthritis (M05.79, bilateral hands and wrists), RF-positive and anti-CCP-positive, with new erosive disease on imaging. Disease activity: moderate (CDAI 18), worsened from low disease activity (CDAI 9) despite methotrexate 20 mg/week for 4 months. Inadequate response to first-line csDMARD therapy per ACR 2021 criteria. Complicated by steroid-induced osteopenia (T-score −1.8 at lumbar spine) and hypertension (BP 142/88 on current regimen). Cardiovascular risk elevated given active RA inflammation and hypertension."

TREAT: "1) Continue methotrexate 20 mg SC weekly with folic acid 1 mg daily. 2) Add adalimumab (Humira) 40 mg SC every 2 weeks after confirming negative TB screen (QuantiFERON [date]: negative) and hepatitis B immunity (anti-HBs positive). 3) Taper prednisone from 10 mg to 5 mg daily over 4 weeks targeting discontinuation. 4) Ordered DEXA scan given steroid use >3 months; started calcium 1200 mg + vitamin D3 2000 IU daily. 5) Rheumatology follow-up in 12 weeks for CDAI reassessment; target: ≥50% improvement at 3 months, low disease activity or remission at 6 months. 6) Educated patient on biologic injection technique, infection signs requiring urgent evaluation, and influenza/pneumococcal vaccination schedule."

Clinical Documentation Elements

Reflecting disease chronicity, severity, and clinical trajectory

- ***Link serostatus to prognosis:*** *Document RF and anti-CCP results with interpretation. Seropositive RA (M05.x) has higher rates of erosive disease and extra-articular manifestations than seronegative RA (M06.0x)*
- ***Record disease activity state with a validated measure:*** *CDAI score and category (remission/low/moderate/high) at each encounter. This directly supports treat-to-target care and MIPS #177*
- ***Specify joint involvement and laterality:*** *"Seropositive RA involving bilateral hands, wrists, and right knee" rather than "RA." Site specificity supports accurate ICD-10 coding*
- ***Document treatment response and clinical reasoning:*** *Show how management decisions reflect the patient's disease activity, comorbidities, and broader clinical context—not just medication names*
- ***Reconfirm diagnosis annually:*** *RA requires active documentation each calendar year. "History of RA" converts to Z-codes and does not map to an HCC. Document the condition as current, actively managed, with MEAT elements*

Reframing Common Documentation Shortcuts

INSTEAD OF…	DOCUMENT…	WHY THIS SUPPORTS CLARITY
"RA"	"Seropositive RA, RF-positive, bilateral hands/wrists (M05.79), CDAI 8 (low disease activity)"	Specifies serostatus, site, activity state; supports M05.x coding and continuity of the clinical record
"RA stable"	"Seropositive RA in sustained low disease activity (CDAI 6, stable over 12 months) on methotrexate 15 mg/week"	Quantifies stability with a validated measure; documents treatment and trajectory
"RA on meds"	"RA managed with methotrexate 20 mg SC weekly + adalimumab 40 mg SC q2 weeks; CDAI 4 (near remission); no flares in 6 months"	Specifies agents, doses, route; links treatment to disease activity outcome
"Arthritis"	"Seronegative rheumatoid arthritis (M06.09), moderate disease activity (CDAI 16), with bilateral wrist synovitis"	Distinguishes RA from osteoarthritis; provides serostatus and disease activity for accurate coding
"Doing well"	"CDAI 2.5 (remission), no tender or swollen joints on exam, ESR 8, CRP <0.5; tolerating MTX without hepatotoxicity (ALT 22)"	Replaces subjective assessment with objective data; demonstrates monitoring and safety surveillance
"Noncompliant with meds"	"Patient reports difficulty with weekly MTX injections due to hand deformity; discussed autoinjector option and pharmacy delivery; agreed to 4-week trial"	Identifies the specific barrier and documents collaborative problem-solving; preserves patient dignity

ABBREVIATIONS: ALT = alanine aminotransferase; CDAI = Clinical Disease Activity Index; CRP = C-reactive protein; ESR = erythrocyte sedimentation rate; MTX = methotrexate; RA = rheumatoid arthritis; RF = rheumatoid factor; SC = subcutaneous

4 TREATMENT AND REFERRAL QUICK GUIDE

Evidence-Based Treatment Protocols

(ACR 2021/EULAR 2022-Aligned)[1,20,22]

CLINICAL SCENARIO	FIRST LINE	DODE/DURATION	ALTERNATIVE
DMARD-naïve, moderate-to-high disease activity	methotrexate	7.5–25 mg weekly (oral or SC); titrate q4–8 wk to max tolerated dose	Leflunomide 10–20 mg daily OR sulfasalazine 2–3 g daily (divided)
DMARD-naïve, low disease activity	hydroxychloroquine	200–400 mg daily	Sulfasalazine, methotrexate, or leflunomide
Inadequate response to first csDMARD	Add TNF inhibitor (adalimumab, etanercept, or biosimilar) + background MTX	Per agent labeling; maintain MTX if tolerated	Triple therapy (MTX + SSZ + HCQ) OR IL-6 inhibitor (tocilizumab, sarilumab) OR abatacept
Failure of ≥2 bDMARDs or contraindication	JAK inhibitor (tofacitinib 5 mg BID, baricitinib 2 mg daily, or upadacitinib 15 mg daily)	Per agent labeling; FDA boxed warning for ≥50 with CV risk factors	Rituximab 1000 mg IV at weeks 0 and 2, repeated q6 months
Glucocorticoid bridge during DMARD initiation	prednisone ≤10 mg daily	Short-term (≤3 months); taper as DMARD effect emerges	Intra-articular corticosteroid for 1–2 active joints; avoids systemic exposure

ABBREVIATIONS: bDMARD = biologic disease-modifying antirheumatic drug; BID = twice daily; csDMARD = conventional synthetic disease-modifying antirheumatic drug; CV = cardiovascular; HCQ = hydroxychloroquine; IL-6 = interleukin-6; IV = intravenous; JAK = Janus kinase; MTX = methotrexate; SC = subcutaneous; SSZ = sulfasalazine; TNF = tumor necrosis factor

Therapy Escalation Criteria[1,20]

TRIGGER	SECTION	EXPECTED BENEFIT
CDAI >10 (moderate) on csDMARD ×3 months	Optimize MTX dose to 25 mg/week (SC preferred for bioavailability)	≥50% improvement target at 3 months
Inadequate response to MTX at max tolerated dose	Add bDMARD (TNF inhibitor preferred first-line) OR triple therapy (MTX + SSZ + HCQ)	Low disease activity or remission at 6 months
Failure of first bDMARD or intolerance	Switch mechanism of action (e.g., TNF inhibitor → IL-6 inhibitor or T-cell costimulation inhibitor)	Different pathway may achieve response where TNFi did not
Failure of ≥2 bDMARDs	Consider JAK inhibitor (with FDA boxed warning counseling for patients ≥50 with CV risk factors)	Oral option; rapid onset; monitor for MACE, VTE, malignancy
Active disease with glucocorticoid dependence (>5 mg/day prednisone >3 months)	Escalate DMARD therapy to enable steroid taper	Reduced steroid-related complications (osteoporosis, diabetes, infection)

ABBREVIATIONS: bDMARD = biologic disease-modifying antirheumatic drug; CDAI = Clinical Disease Activity Index; csDMARD = conventional synthetic disease-modifying antirheumatic drug; CV = cardiovascular; HCQ = hydroxychloroquine; IL-6 = interleukin-6; JAK = Janus kinase; MACE = major adverse cardiovascular events; MTX = methotrexate; SC = subcutaneous; SSZ = sulfasalazine; TNF = tumor necrosis factor; TNFi = TNF inhibitor; VTE = venous thromboembolism

CLINICAL PEARL: CDAI SCORE AND THERAPY ESCALATION

During Follow-up (Every 1–3 Months)

- ***Assess the Trend:*** *A significant increase (e.g., moving from a CDAI score of 8 to 14) justifies a change in medication, even if the patient is "coping" with the pain.*
- ***Screen for Erosions:*** *If the CDAI remains in the Moderate or High range for more than 3 months, order X-rays to check for new structural damage.*

Addressing Frailty and Safety

In older or frail adults, the CDAI helps justify the use of biologics over high-dose steroids.

- ***Clinical Logic:*** *If the CDAI is >10, but the patient is already at their maximum tolerated dose of Methotrexate, the objective score provides the rationale for adding a biologic to facilitate a Prednisone taper (targeting the <10 mg "Safety Zone").*

Practical Example: *"Patient's **CDAI is 16 (Moderate Activity)** today, up from 9 (Low Activity) at the previous visit. Examination reveals 4 swollen and 6 tender joints. Patient global assessment is 3/10. Given this increase and the presence of **pre-frailty**, we will initiate Adalimumab as a step-up from MTX monotherapy to achieve a target CDAI of <10 and allow for a steroid taper to 5 mg"*

Choosing a Biologic[21]

PATIENT PROFILE	RECOMMENDED BIOLOGIC	CLINICAL RATIONALE & ACTION
High Infection Risk or Frailty	Abatacept (Orencia) No biosimilars available	Preferred for elderly or medically fragile patients; clinical data indicates a lower risk of serious infections compared to TNF-inhibitors
Concurrent Lung Disease (ILD/COPD)	Abatacept or Rituximab	Preferred over TNF-inhibitors, which have been occasionally linked to ILD exacerbations; these options are considered safer for lung health
High RF/CCP or Vasculitis	Rituximab Biosimilars: truxima, ruxience	Highly effective for "seropositive" patients with high autoantibody titers or extra-articular (outside the joint) manifestations
Requirement for Rapid Relief	IL-6 Inhibitors (e.g., Tocilizumab) Biosimilars: tofidence, tyenne, and avtozma	Offers very fast onset of action; exceptionally effective as a monotherapy for patients who cannot tolerate Methotrexate

ABBREVIATIONS: bDMARD = biologic disease-modifying antirheumatic drug; BID = twice daily; csDMARD = conventional synthetic disease-modifying antirheumatic drug; CV = cardiovascular; HCQ = hydroxychloroquine; IL-6 = interleukin-6; IV = intravenous; JAK = Janus kinase; MTX = methotrexate; SC = subcutaneous; SSZ = sulfasalazine; TNF = tumor necrosis factor

Preventative and Non-RX Treatments[23]

1. Physical and Occupational Therapy (PT/OT)

PT and OT are not merely "supportive"; they are functional interventions that directly impact the **HAQ score** (Health Assessment Questionnaire) and frailty status.

- **Joint Protection Techniques:** OT provides education on using larger joints to perform tasks (e.g., using the palm instead of fingers to open a jar) and the use of assistive devices (splints, ergonomic reachers) to reduce mechanical stress
- **Therapeutic Exercise:** A balance of **range-of-motion (ROM)** exercises to prevent contractures and **low-impact aerobic conditioning** (e.g., aquatic therapy or cycling) to improve cardiovascular health—crucial given that RA carries a CV risk profile comparable to diabetes
- **Resistance Training:** Targeted strengthening of the muscles surrounding affected joints (e.g., quadriceps strengthening for knee RA) stabilizes the joint and reduces pain

2. Complementary Therapies

Since RA is a chronic condition, managing the mental and physical stress it causes is a major part of treatment.

- **Yoga and Tai Chi:** These combine gentle movement with deep breathing. They are particularly effective for improving balance and reducing the "brain fog" often associated with chronic pain
- **Acupuncture:** Some evidence suggests it can stimulate the release of endorphins (natural painkillers) and improve blood flow to affected areas
- **Massage Therapy:** Gentle massage (like Swedish massage) can reduce cortisol levels and alleviate muscle tension surrounding inflamed joints
- **Heat and Cold Therapy:** * **Heat:** Warm showers or heating pads relax stiff muscles and increase blood flow (best for morning stiffness)
- **Cold:** Ice packs or cold compresses numb sharp pain and reduce swelling (best after activity or during a flare)

3. Dietary and Metabolic Stabilization

Metabolic health plays a critical role in systemic inflammation and the "safety-first" management of RA.

- **Anti-Inflammatory Nutrition:** High adherence to a **Mediterranean-style diet** (rich in Omega-3 fatty acids, olive oil, and antioxidants) has been shown in some studies to reduce pain and morning stiffness
- **Weight Management:** Reducing adipose tissue is critical because fat cells produce **adipokines**, which are pro-inflammatory signaling molecules. Weight loss also reduces the mechanical load on "weight-bearing" joints (hips and knees)
- **Bone Health Support:** Since many RA patients are at risk for steroid-induced osteoporosis, non-drug support includes weight-bearing exercise and ensuring adequate dietary intake of Calcium and Vitamin D

Documentation Example: "Referred to occupational therapy for bilateral hand splinting, joint protection strategies, and adaptive device evaluation. Physical therapy consult placed for strengthening program targeting lower extremity deconditioning from limited mobility during flare. Patient educated on importance of regular low-impact exercise (swimming, cycling) for joint preservation and cardiovascular health. Smoking cessation counseling provided given active smoking status and its role in RA disease activity and CV risk. Annual influenza and age-appropriate pneumococcal vaccinations administered today; documented in immunization record."

AAVBC PERSPECTIVE

*AAVBC advocates for an integrated treatment model that pairs affordable **csDMARDs**—such as **MTX** and **HCQ**—with comprehensive lifestyle interventions, including physiotherapy, occupational therapy, and evidence-based nutrition. This synergistic approach effectively controls synovial inflammation while proactively mitigating systemic comorbidities such as cardiovascular disease and osteoporosis.*

When to Refer[10,11,23]

SPECIALITY	URGENT (<2 WEEKS)	ROUTINE (4–6 WEEKS)
Rheumatology	New suspected RA with elevated inflammatory markers; polyarticular flare on current DMARD; suspicion of vasculitis or systemic extra-articular manifestation	Inadequate response to first csDMARD at 3 months; DMARD initiation guidance for PCP-managed patients; disease activity monitoring for treat-to-target
Pulmonology	Acute dyspnea/hypoxia with new infiltrates in RA patient (ILD exacerbation); suspected drug-induced pneumonitis	Chronic dry cough; baseline PFTs for patients starting MTX/LEF; ILD surveillance in high-risk patients
Cardiology	Chest pain or acute coronary syndrome symptoms (lower threshold in RA)	CV risk stratification; statin initiation in patients with active RA and CV risk factors
Orthopedic surgery	Cervical spine instability with neurologic symptoms	Joint replacement evaluation; perioperative DMARD coordination per 2022 ACR/AAHKS guideline
Ophthalmology	Severe eye pain, photophobia, vision changes (scleritis)	Annual screening for hydroxychloroquine retinal toxicity (after 5 years of use or sooner if risk factors)

ABBREVIATIONS: ACR = American College of Rheumatology; AAHKS = American Association of Hip and Knee Surgeons; csDMARD = conventional synthetic disease-modifying antirheumatic drug; CV = cardiovascular; DMARD = disease-modifying antirheumatic drug; ILD = interstitial lung disease; LEF = leflunomide; MTX = methotrexate; PCP = primary care provider; PFT = pulmonary function test; RA = rheumatoid arthritis

Follow-Up Timing[23,24]

CLINICAL STATUS	TIMING	KEY ASSESSMENT DETAILS
New diagnosis or new DMARD initiation	Every 1–3 months	Disease activity (CDAI), DMARD safety labs (CBC, CMP), treatment response, adverse effects
Active disease (moderate/high)	Every 1–3 months until target achieved	CDAI trend, treatment escalation assessment, glucocorticoid taper progress
Stable low disease activity or remission	Every 3–6 months	CDAI, safety labs per DMARD schedule, comorbidity screening, vaccination status
Biologic/JAK inhibitor therapy	Per agent monitoring schedule; minimum q3 months	Infection screening, CBC, CMP, lipids (JAK inhibitors); disease activity
Post-flare or treatment change	4–8 weeks after change	Early response assessment; adverse effect monitoring; patient-reported symptoms

ABBREVIATIONS: CBC = complete blood count; CDAI = Clinical Disease Activity Index; CMP = comprehensive metabolic panel; DMARD = disease-modifying antirheumatic drug; JAK = Janus kinase

Patient Education and Adherence[21,23]

1. Flare Management

It is important to distinguish between daily pain and the systemic "fire" of RA.

- **Morning Stiffness:** Explain that stiffness lasting more than 30–60 minutes is a sign of active inflammation. If this is increasing, the "fire" is growing, even if the pain is manageable.
- **The Treatment Goal:** Educate patients on Treat-to-Target. The goal isn't just "feeling better"—it is achieving Remission (virtually no swelling) to stop permanent bone erosions.
- **Rest vs. Movement:** During a flare, rest the joint. Once the flare subsides, gentle movement (like swimming or cycling) is medicine. "Motion is lotion" for arthritic joints.

2. The "Stability vs. Safety" Trade-off

Adherence is not just about controlling pain; it is about keeping the immune system balanced—not too active (causing joint damage) and not too suppressed (causing sepsis).

- **The Flare-Up Cycle:** "Skipping doses" allows the inflammatory fire to restart, which makes it much more difficult to manage, requiring higher doses of steroids
- **The Steroid "Safe Zone":** Focus on the goal of getting below 10 mg/day. Explain that adherence to "anchor" drugs (like Minocycline or Sulfasalazine) is what "buys" them the ability to lower their steroid dose, which helps avoid infections and steroid-induced side effects

Example Documentation: "Educated patient on RA as a chronic inflammatory condition requiring ongoing DMARD therapy even during periods of remission. Discussed treat-to-target approach: goal of CDAI ≤2.8 (remission) or ≤10 (low disease activity). Reviewed methotrexate administration technique (SC injection), importance of folic acid supplementation, and signs of toxicity (mouth sores, easy bruising, persistent cough). Patient verbalized understanding. Provided written materials in patient's preferred language. Discussed importance of adherence to biologic injection schedule and not discontinuing without clinician guidance. Follow-up labs scheduled before next visit."

Comorbidity Management[7,8,10,25]

CONDITION	AVOID	REASON	ALTERNATIVE
CKD (eGFR <45)	Methotrexate at standard dose; NSAIDs	MTX: reduced renal clearance, increased toxicity; NSAIDs: further renal impairment	Reduce MTX dose or switch to hydroxychloroquine/ sulfasalazine; biologics generally safe
Heart failure	TNF inhibitors (infliximab, adalimumab) at high doses; NSAIDs	TNF inhibitors may worsen NYHA class III–IV HF; NSAIDs cause fluid retention	IL-6 inhibitors, abatacept, or rituximab; low-dose corticosteroid bridge if needed
Recurrent infections	High-dose glucocorticoids (>10 mg/day); biologic escalation	Dose-dependent infection risk up to 4-fold increase with steroids; biologics add 1.5–2× risk	Minimize steroid exposure; hydroxychloroquine or sulfasalazine as steroid-sparing agents
Osteoporosis (steroid-induced)	Chronic prednisone >5 mg/day without bone protection	74.5% of geriatric RA on steroids; 64.9% have osteoporosis	DEXA at steroid initiation; calcium/vitamin D; bisphosphonate if T-score ≤−1.5 on steroids
Diabetes/steroid-induced hyperglycemia	Prolonged glucocorticoid courses without glucose monitoring	33.6% of geriatric RA patients have diabetes; steroids worsen glycemic control	Monitor glucose; adjust insulin/oral agents; taper steroids as DMARD takes effect

ABBREVIATIONS: CKD = chronic kidney disease; DEXA = dual-energy X-ray absorptiometry; DMARD = disease-modifying antirheumatic drug; eGFR = estimated glomerular filtration rate; HF = heart failure; IL-6 = interleukin-6; MTX = methotrexate; NSAID = nonsteroidal anti-inflammatory drug; NYHA = New York Heart Association; RA = rheumatoid arthritis; TNF = tumor necrosis factor

Cost-Smart Options[23]

MEDICATION	STANDARD RETAIL	DISCOUNT PRICE	COST-SMART TIP
Methotrexate 2.5 mg tabs (generic)	~$15–$30/ month	~$4–$10/month (GoodRx coupon)	First-line DMARD; oral form is inexpensive; SC autoinjectors cost more but improve bioavailability
Minocycline (generic)	~$15–$40/ month	~$15–$20/month (GoodRx coupon for 90-day supply)	First-line generic; Low "out-of-pocket" burden; no specialty pharmacy required
Hydroxychloroquine 200 mg (generic)	~$20–$40/ month	~$8–$15/month	Low-cost option for mild disease; requires annual eye exam after 5 years
Sulfasalazine 500 mg (generic)	~$15–$35/ month	~$8–$15/month	Affordable alternative or combination therapy agent
Adalimumab biosimilar (Hadlima, Hyrimoz)	~$1,038–$200/month	~$900–$1,300/ month (specialty pharmacy)	Biosimilars offer 40–60% savings vs. originator Humira; check plan formulary
Prednisone 5 mg (generic)	~$5–$10/ month	~$3–$5/month	Short-term bridge only; document taper plan; monitor glucose and bone density
Folic acid 1 mg (generic)	~$3–$8/month	~$2–$4/month (OTC)	Required with methotrexate; reduces GI and hepatic side effects

ABBREVIATIONS: DMARD = disease-modifying antirheumatic drug; GI = gastrointestinal; OTC = over the counter; SC = subcutaneous

AAVBC PERSPECTIVE

*AAVBC advocates for a **stratified, risk-mitigated approach** to respiratory therapy, prioritizing safety by minimizing exposure to the severe adverse effects—such as malignancy or opportunistic infections—associated with high-potency biologics. We support a protocol that follows a **'conservative-first' escalation model**, initiating care with low-cost, low-risk first-line agents. Treatment is then tailored to the patient's unique clinical phenotype, accounting for individual risk factors and disease severity, with the strategic integration of **biosimilars** once clinical stability and cost-effectiveness are aligned*

Quality Metrics Tie-In[6,26]

MEASURE	TARGET	STAR RATING CONTEXT
DMARD therapy for RA (HEDIS ART)	≥1 DMARD Rx/year for patients with RA diagnosis	Historical HEDIS measure; ~63% performance in Medicare MA
Periodic disease activity assessment (MIPS #177)	ACR-preferred tool (CDAI, SDAI, or DAS28) at ≥50% of RA encounters	Directly supports treat-to-target RA care; documents clinical decision-making
Functional status assessment (MIPS #178)	≥1 validated tool (HAQ, MDHAQ, or PROMIS PF) per performance period	Documents functional impact of RA; supports comprehensive care documentation
Statin therapy for cardiovascular disease (Star C19)	≥1 statin dispensed in measurement year for patients with CVD	RA confers 2-fold CV risk; co-management with statin therapy reflects quality care
Controlling blood pressure (Star C14)	BP <140/90 mmHg	72.4% of geriatric RA patients have hypertension; NSAIDs elevate BP; monitor closely

ABBREVIATIONS: ACR = American College of Rheumatology; ART = Arthritis-Related Therapy; BP = blood pressure; CDAI = Clinical Disease Activity Index; CV = cardiovascular; CVD = cardiovascular disease; DAS28 = Disease Activity Score 28; DMARD = disease-modifying antirheumatic drug; HAQ = Health Assessment Questionnaire; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; MDHAQ = Multi-Dimensional Health Assessment Questionnaire; MIPS = Merit-based Incentive Payment System; NSAID = nonsteroidal anti-inflammatory drug; PROMIS PF = Patient-Reported Outcomes Measurement Information System Physical Function; RA = rheumatoid arthritis; SDAI = Simplified Disease Activity Index

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity[3–5]

CRITICAL ELEMENT	CLINICAL REQUIREMENT	EXAMPLE DOCUMENTATION
Serostatus	Specify RF-positive (M05.x) vs. seronegative (M06.0x) based on laboratory results	"Seropositive RA, RF 145 IU/mL, anti-CCP >250 U/mL" → M05.79 (multiple sites)
Site specificity	Document specific joints involved; use "multiple sites" codes when >1 anatomic area	"RA involving bilateral hands, wrists, and right knee" → M05.79 (seropositive, multiple sites)
Disease activity state	Record validated measure score and category at each visit	"CDAI 18 (moderate disease activity)" — supports clinical decision-making
Active vs. history	RA must be documented as a current, actively managed condition	"Active seropositive RA on methotrexate" (HCC 93) vs. "History of RA" (Z-code, no HCC)
Extra-articular manifestations	Document organ-specific involvement with appropriate sub-codes	"Seropositive RA with rheumatoid lung disease" → M05.10 (supports ILD management documentation)
Treatment status	Document current DMARD, response, and rationale for any changes	"MTX 20 mg/week SC × 4 months, inadequate response (CDAI 18); adding adalimumab per ACR 2021"

ABBREVIATIONS: ACR = American College of Rheumatology; anti-CCP = anti-cyclic citrullinated peptide; CDAI = Clinical Disease Activity Index; DMARD = disease-modifying antirheumatic drug; HCC = Hierarchical Condition Category; ILD = interstitial lung disease; MIPS = Merit-based Incentive Payment System; MTX = methotrexate; RA = rheumatoid arthritis; RF = rheumatoid factor; SC = subcutaneous

DOCUMENTATION TIP

Using the phrase **"History of RA"** suggests the condition is cured or inactive. This results in a non-HCC Z-code, failing to document the patient's true medical complexity and potentially leading to a loss of resources necessary to support the patient's long-term specialty care. RA in remission still requires a face-to-face or synchronous audio-visual encounter with MEAT documentation by 12/31 to support HCC 93 eligibility.

Annual Clinical Review and Confirmation

Confirm RA remains active, specified, and clinically managed.

- ***Annual review:*** *RA must be reassessed once per calendar year via face-to-face or synchronous audio-video encounter, with MEAT documented by 12/31*
- ***Visit modality:*** *In-person or video telehealth encounters qualify when they support meaningful evaluation of disease activity and treatment response*
- ***Clinical context:*** *Under HCC V28, RA maps to HCC 93 (RAF ~0.617). Documenting as "history of RA" results in a Z-code with no HCC mapping, eliminating the clinical complexity signal from the record*
- ***Reconfirm serostatus:*** *If original serologies are in the chart, reference them. If not, order RF/anti-CCP to support M05.x vs. M06.0x specificity*
- ***Update disease activity:*** *Document current CDAI (or equivalent validated measure) and compare to prior scores to show trajectory*

Good Documentation is Comprehensive Coding

INSUFFICIENT	COMPREHENSIVE
"RA" (no serostatus, no activity, no site)	→ "Seropositive RA (M05.79), RF-positive, bilateral hands/wrists, CDAI 6 (low disease activity), on MTX 15 mg/week SC"
"Arthritis, stable" (nonspecific diagnosis)	→ "Seronegative RA (M06.09), CDAI 2.5 (remission), sustained ×12 months on MTX + HCQ; no active synovitis on exam"
"History of RA" (inactive framing)	→ "Active seropositive RA, currently managed with adalimumab 40 mg q2wk + MTX 20 mg/wk; CDAI 8 (low); last flare 9 months ago"
"RA, continue meds" (no specifics)	→ "Seropositive RA (M05.79), moderate activity (CDAI 14); continuing MTX 20 mg SC weekly; discussed escalation to biologic; patient prefers 3-month reassessment first"
"Joint pain, RA" (symptom-level only)	→ "Seropositive RA with rheumatoid lung disease (M05.10), high disease activity (CDAI 24); CXR shows stable bilateral lower lobe reticular changes; PFTs stable; escalating to tocilizumab"

ABBREVIATIONS: CDAI = Clinical Disease Activity Index; CXR = chest X-ray; HCQ = hydroxychloroquine; MTX = methotrexate; PFT = pulmonary function test; RA = rheumatoid arthritis; RF = rheumatoid factor; SC = subcutaneous

EHR Tips

- ***.RAVISIT*** *— SmartPhrase/dot-phrase template auto-populating: CDAI score fields (TJC28, SJC28, patient global, evaluator global), serostatus, current DMARD regimen, disease activity category, and follow-up plan*
- ***.RAMEAT*** *— Pre-structured MEAT documentation template: Monitor (labs with dates), Evaluate (exam findings), Assess (ICD-10 with severity/trajectory), Treat (medications, referrals, education)*
- ***.RAESCALATE*** *— Treatment escalation decision template: documents current therapy, reason for change, new therapy selected, ACR 2021 guideline alignment, infection screening status*
- ***BPA trigger:*** *Alert when RA diagnosis is on problem list but no CDAI or disease activity measure documented in prior 6 months*
- ***Order set:*** *"RA Monitoring Labs" — CBC, CMP, ESR, CRP; frequency linked to DMARD type and disease activity*

Case Examples

SUCCESS

"68-year-old woman with seropositive RA (M05.79), RF 210 IU/mL, anti-CCP >250 U/mL, bilateral hand and wrist involvement. CDAI improved from 22 (moderate) to 6 (low disease activity) after 6 months of methotrexate 20 mg SC weekly + adalimumab 40 mg q2wk. Erosive disease stable on follow-up hand films. DEXA ordered (prednisone 5 mg ×3 months, now tapered to 2.5 mg). CV risk addressed: started atorvastatin 20 mg for LDL 142 mg/dL given RA-associated CV risk. Annual influenza and pneumococcal vaccines administered."

Proper documentation of disease activity measured (CDAI), treatment response documented, comorbidities addressed, and prevention completed.

PITFALL

"72-year-old man with "arthritis, continue meds." Problem list includes "RA." Labs show RF 85 IU/mL from 2019 but no recent disease activity assessment. Medications: methotrexate 15 mg weekly, prednisone 10 mg daily for 14 months. No documentation of serostatus in current note, no site specificity, no CDAI, no steroid taper plan, no bone density evaluation despite chronic steroid use."

No documentation of disease activity. Chronic steroid use without taper plan and DEXA represents quality gap and patient risk.

FIX

"72-year-old man with seropositive RA (M05.79, multiple sites), RF 85 IU/mL (confirmed from [date] laboratory records). CDAI today: 12 (moderate disease activity)—tender joints 4/28, swollen joints 3/28, patient global 4/10, evaluator global 3/10. Current therapy: methotrexate 15 mg weekly ×18 months with inadequate response. Prednisone 10 mg daily ×14 months—initiated taper to 7.5 mg this week, targeting ≤5 mg by 8 weeks. DEXA ordered today given >3 months of steroid use; started calcium 1200 mg + vitamin D3 2000 IU daily. Discussing escalation to biologic DMARD given persistent moderate activity on optimized methotrexate; TB screening and hepatitis B panel ordered. Rheumatology referral placed. Follow-up in 6 weeks for CDAI reassessment and escalation decision."

Specifies serostatus with laboratory confirmation, documents disease activity with validated measure, addresses steroid complications, and establishes a treat-to-target escalation plan.

REFERENCES

1. Di Matteo A, Bathon JM, Emery P. Rheumatoid arthritis. *Lancet Lond Engl*. 2023;402(10416):2019-2033. doi:10.1016/S0140-6736(23)01525-8
2. Aletaha D, Neogi T, Silman AJ, et al. 2010 Rheumatoid arthritis classification criteria: an American College of Rheumatology/European League Against Rheumatism collaborative initiative. *Ann Rheum Dis*. 2010;69(9):1580-1588. doi:10.1136/ard.2010.138461
3. Curtis JR, Xie F, Zhou H, Salchert D, Yun H. Use of ICD-10 diagnosis codes to identify seropositive and seronegative rheumatoid arthritis when lab results are not available. *Arthritis Res Ther*. 2020;22(1): 242. doi:10.1186/s13075-020-02310-z
4. Zhu JR, Galivanche AR, Gouzoulis MJ, et al. *International Classification of Diseases* Coding for Inflammatory Arthritides. *JAMA Netw Open*. 2024;7(4):e246544. doi:10.1001/jamanetworkopen.2024.6544
5. Lee CS, Monticciolo DL, Moy L. Screening Guidelines Update for Average-Risk and High-Risk Women. *Am J Roentgenol*. 2020;214(2):316-323. doi:10.2214/AJR.19.22205
6. Seyferth AV, Cichocki MN, Wang CW, et al. Factors Associated With Quality Care Among Adults With Rheumatoid Arthritis. *JAMA Netw Open*. 2022;5(12):e2246299. doi:10.1001/jamanetworkopen.2022.46299
7. Burmester GR, Pope JE. Novel treatment strategies in rheumatoid arthritis. *The Lancet*. 2017;389(10086):2338-2348. doi:10.1016/S0140-6736(17)31491-5
8. Figus FA, Piga M, Azzolin I, McConnell R, Iagnocco A. Rheumatoid arthritis: Extra-articular manifestations and comorbidities. *Autoimmun Rev*. 2021;20(4):102776. doi:10.1016/j.autrev.2021.102776
9. Pavlov-Dolijanovic S, Bogojevic M, Nozica-Radulovic T, Radunovic G, Mujovic N. Elderly-Onset Rheumatoid Arthritis: Characteristics and Treatment Options. *Medicina (Mex)*. 2023;59(10):1878. doi:10.3390/medicina59101878
10. Berman S, Bucher J, Koyfman A, Long BJ. Emergent Complications of Rheumatoid Arthritis. *J Emerg Med*. 2018;55(5):647-658. doi:10.1016/j.jemermed.2018.07.030
11. Auyezkhankyzy D, Izekenova A, Kocyigit BF. Emergencies in inflammatory rheumatic diseases. *Rheumatol Int*. 2024;44(9):1637-1646. doi:10.1007/s00296-024-05660-y
12. Aletaha D, Smolen JS. Diagnosis and Management of Rheumatoid Arthritis: A Review. *JAMA*. 2018;320(13):1360. doi:10.1001/jama.2018.13103
13. Kay J, Upchurch KS. ACR/EULAR 2010 rheumatoid arthritis classification criteria. *Rheumatology*. 2012;51(suppl 6):vi5-vi9. doi:10.1093/rheumatology/kes279
14. O'Dell JR. Therapeutic Strategies for Rheumatoid Arthritis. Wood AJJ, ed. *N Engl J Med*. 2004;350(25): 2591-2602. doi:10.1056/NEJMra040226
15. Listing J, Gerhold K, Zink A. The risk of infections associated with rheumatoid arthritis, with its comorbidity and treatment. *Rheumatology*. 2013;52(1):53-61. doi:10.1093/rheumatology/kes305
16. Goodman SM, Springer BD, Chen AF, et al. 2022 American College of Rheumatology/American Association of Hip and Knee Surgeons Guideline for the Perioperative Management of Antirheumatic Medication in Patients With Rheumatic Diseases Undergoing Elective Total Hip or Total Knee Arthroplasty. *Arthritis Care Res*. 2022;74(9):1399-1408. doi:10.1002/acr.24893
17. Agca R, Heslinga SC, Rollefstad S, et al. EULAR recommendations for cardiovascular disease risk management in patients with rheumatoid arthritis and other forms of inflammatory joint disorders: 2015/2016 update. *Ann Rheum Dis*. 2017;76(1):17-28. doi:10.1136/annrheumdis-2016-209775
18. Kara M, Alp G, Palanbek Yavaş S, et al. The effect of polypharmacy on rheumatoid and psoriatic arthritis treatment: retrospective study. *PeerJ*. 2023;11:e16418. doi:10.7717/peerj.16418
19. England BR, Tiong BK, Bergman MJ, et al. 2019 Update of the American College of Rheumatology Recommended Rheumatoid Arthritis Disease Activity Measures. *Arthritis Care Res*. 2019;71(12): 1540-1555. doi:10.1002/acr.24042
20. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Care Res*. 2021;73(7):924-939. doi:10.1002/acr.24596
21. Singh JA, Wells GA, Christensen R, et al. Adverse effects of biologics: a network meta-analysis and Cochrane overview. Cochrane Musculoskeletal Group, ed. *Cochrane Database Syst Rev*. 2011;2016(4). doi:10.1002/14651858.CD008794.pub2
22. Arnold MJ. Management of Rheumatoid Arthritis: Update From ACR. *Am Fam Physician*. 2022;106(3): 340-342.
23. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. *Arthritis Rheumatol*. 2021;73(7):1108-1123.
24. Smolen JS, Edwards CJ, Konzett V, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biologic disease-modifying antirheumatic drugs: 2025 update. *Ann Rheum Dis*. Published online 2026.
25. Tekeoglu S. Comprehensive analysis of rheumatic diseases, comorbidities, and mortality in geriatric population: Real-world data of 515 patients in a single rheumatology clinic. *Medicine (Baltimore)*. 2024;103(48):e40753. doi:10.1097/MD.0000000000040753
26. Schmajuk G, Trivedi AN, Solomon DH, et al. Receipt of disease-modifying antirheumatic drugs among patients with rheumatoid arthritis in Medicare managed care plans. *JAMA*. 2011;305(5):480-486. doi: 10.1001/jama.2011.67

MEDICAL DISCLAIMER

The information provided by the American Academy of Value-Based Care (AAVBC) in this document, including but not limited to coding guidance, and related content, is intended for educational and informational purposes only. This content is designed to assist healthcare providers, organizations, and professionals in understanding and applying Value-Based Care principles, practices, and regulatory compliance standards.

AAVBC does not provide legal, clinical, or medical advice. The content presented should not be interpreted or relied upon as specific legal, medical, clinical, or professional guidance. While efforts are made to ensure the accuracy and currency of the information provided, AAVBC does not guarantee that the materials presented are complete, comprehensive, or without error.

Providers and healthcare professionals must independently evaluate all content and guidance presented herein in the context of applicable laws, regulations, clinical guidelines, payer policies, patient-specific conditions, and contraindications. Any treatments, procedures, diagnostic approaches, medications, or strategies discussed are illustrative and should not be directly applied without a thorough and independent review of current, evidence-based clinical resources, and regulatory requirements.

For coding, documentation, utilization management, quality measures (including STAR ratings), and compliance matters, users are responsible for consulting official guidance issued by regulatory bodies, including but not limited to the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), relevant state agencies, and other authoritative entities.

AAVBC expressly disclaims liability for any loss, claim, or damage arising directly or indirectly from the use of or reliance on information provided in this document. Users should consult their organization's legal counsel, compliance officer, or qualified professional advisor for advice specific to their situation.

By accessing and using this document, you agree to AAVBC's terms and acknowledge that the use of the content is at your own risk and discretion.