Clinical Quality Feedback Supplemental Guide

Updated: March 2022

MEDICARE ADVANTAGE STARS PROGRAM
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INTRODUCTION TO CLINICAL QUALITY FEEDBACK

Highmark's Provider Portal (accessible via NaviNet®) provides channels of communication between our provider partners and Highmark. One of those communication channels is through Clinical Quality Feedback. This function allows providers to submit clinical data documented in the patient's medical record to supplement what does not appear in Highmark claims data.

You can access the Clinical Quality Feedback function through the tab on the Provider Portal homepage highlighted by the red arrow (see Figure 1 on Page 2).

Note: The screenshots provided in this document are illustrative. Pages will vary from practice to practice.

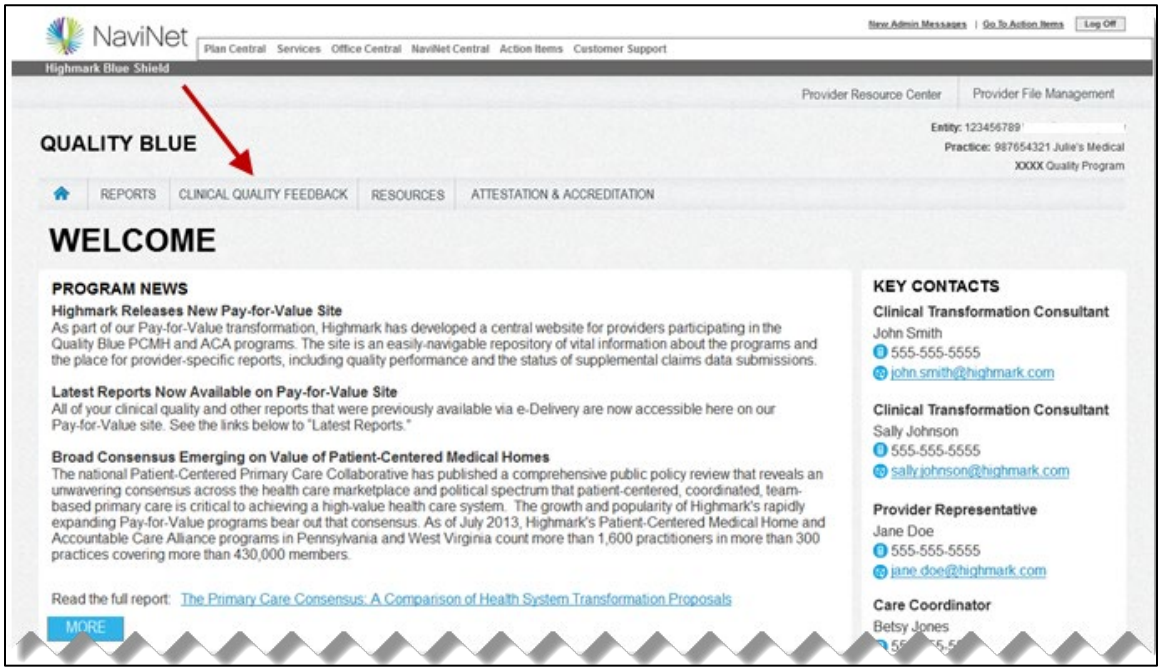

Figure 1: Provider Portal Landing Page

MEASURES AVAILABLE FOR CLINICAL QUALITY FEEDBACK AND DOCUMENTATION

The Clinical Quality Feedback function is not available for all quality measures in Highmark Value-Based Reimbursement programming. When available, and with appropriate documentation, participants can provide information about a particular service or diagnosis through the Clinical Quality Feedback function to exclude a member from the denominator of a quality measure or credit a member for compliance with the numerator of a quality measure. (Measure descriptions and details can be

found in the Masthead Measure Guide specific to the Value-Based Reimbursement Program in which you participate.) There is no limit to the number of measures you can submit data on for each member.

A table is included in the *Appendix* of this document outlining the services and diagnoses that are available for submission through the Clinical Quality Feedback function. If a measure, service, or diagnosis is not included in the table in the *Appendix*, the option to submit that service or diagnosis through the Clinical Quality Feedback function does not exist.

While the Clinical Quality Feedback function is a great tool for clinical communication with Highmark, it is important to note that claims are the most efficient way to provide Highmark with clinical data on your attributed members. It is important to remember the following:

- If a claim was or can be submitted to Highmark for a service or diagnosis, please do not use the Clinical Quality Feedback function. If Highmark has a claim on record for the service or diagnosis and a Clinical Quality Feedback submission is made, the submission will be denied.
- In cases where you have a record of a service or diagnosis for a member but the appropriate code was not submitted, you can submit a claim adjustment for the visit where the service was completed or clinical information was obtained. All claims resubmissions must follow Highmark's claims adjustment policy as outlined by Highmark.

NAVIGATING THE CLINICAL QUALITY FEEDBACK FUNCTION

On the Clinical Quality Feedback homepage (Figure 2 on Page 4), you have the ability to:

1. **View submissions**. All of the submissions you have made within the last 120 days are viewable on the Clinical Quality Feedback homepage. This list is searchable and sortable. Each column (except the "Edit" and "Delete" columns) can be sorted in ascending or descending order by clicking on the up or down arrow in the column header (circled in orange in Figure 2 on Page 4).

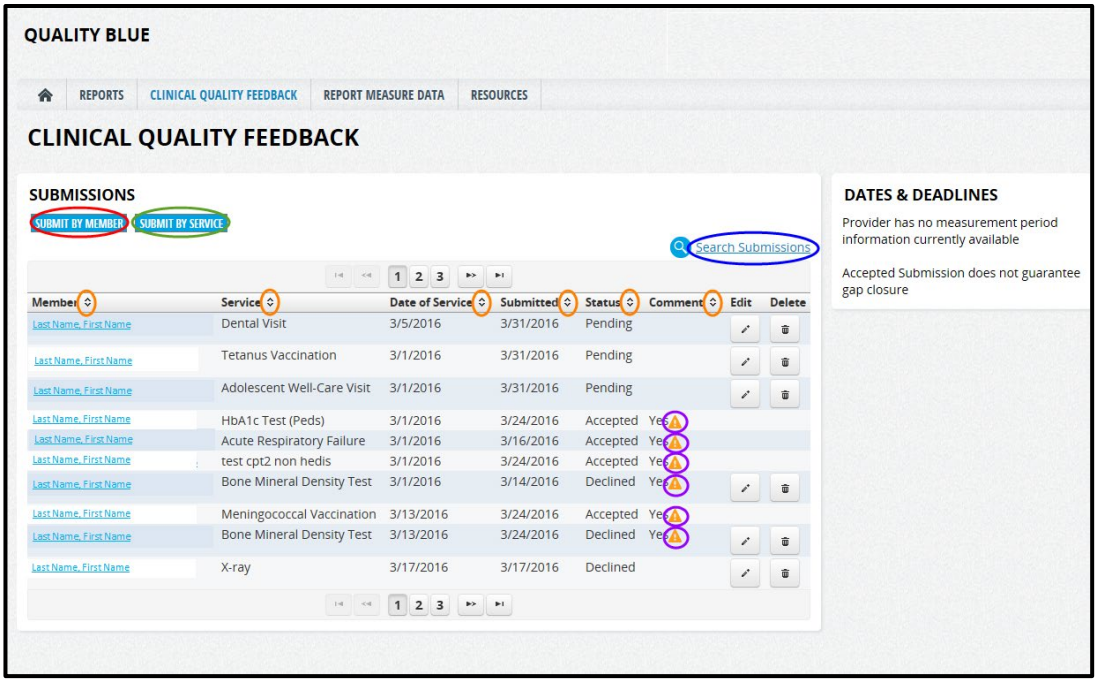

Figure 2: Clinical Quality Feedback Homepage

2. **Search submissions**. By clicking the "Search Submissions" link circled in blue (Figure 2 on Page 4) on the Clinical Quality Feedback homepage, you can search all submissions that you have made, including those that are older than 120 days and no longer showing on the Clinical Quality Feedback homepage. When you click the "Search Submissions" link, you will be taken to another page where you can enter the criteria for your search (see Figure 3 on Page 5). "Status" and "Date Range" are both required search criteria. For "Date Range," you can search by Date of Service or Submission Date. Please note that both date options are limited to a search of 1 to 31 days. There are also other optional search elements, including service, member ID and member name. Results of your search will appear at the bottom of the search screen.

Note: When searching using member ID, use the form of the member ID in which the submission was made.

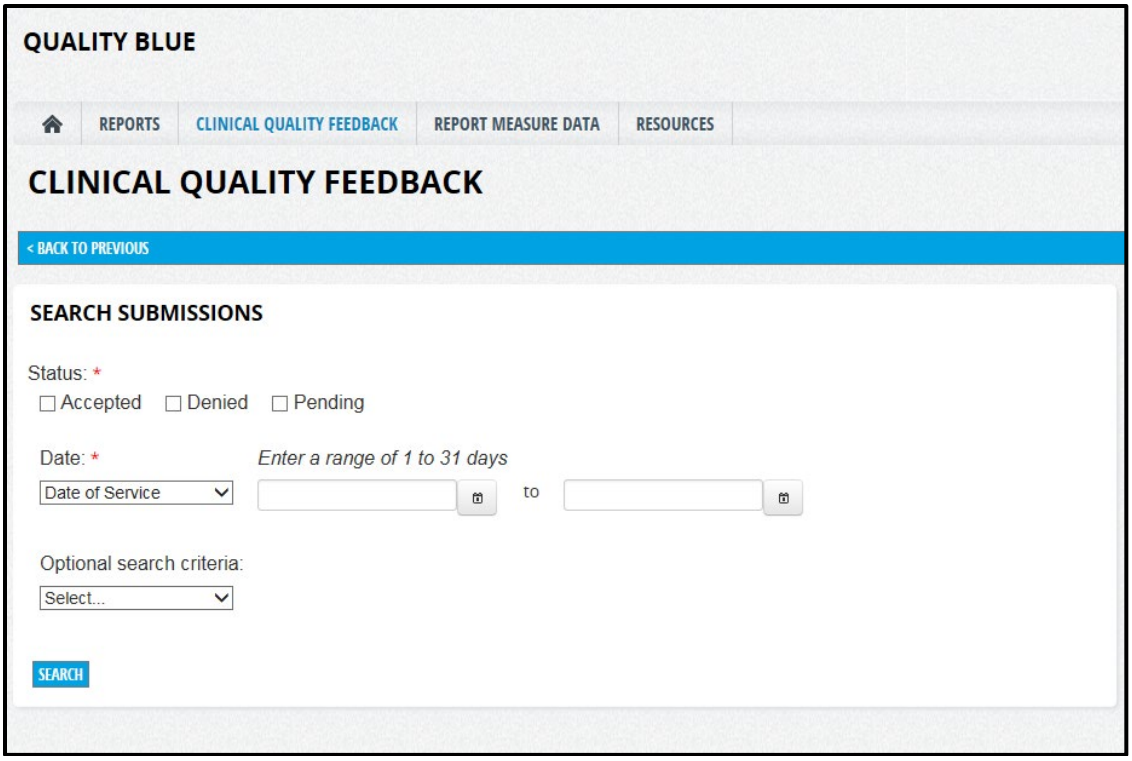

Figure 3: Search Submissions

3. **Edit or delete a submission**. "Pending" and "Declined" submissions can be edited or deleted by clicking on the pencil icon (Edit) or trash can icon (Delete) associated with the submission. Submissions that are "Pending" are those which have not been reviewed by Highmark. Submissions that are "Declined" are those that did not meet the criteria. Reasons for a "Declined" submission are outlined later in this document.
4. **Start a submission**. From the Clinical Quality Feedback homepage, you can either make a submission by member (circled in red in Figure 2 on Page 4) or by service/ diagnosis (circled in green in Figure 2 on Page 4). The following section outlines how to make a submission.

MAKING A SUBMISSION

Starting on the Clinical Quality Feedback homepage (Figure 2 on Page 4), click the "Submit by Member" button circled in red. This will take you to the next page in the submission process (see Figure 4 on Page 6) where you can begin the submission process.

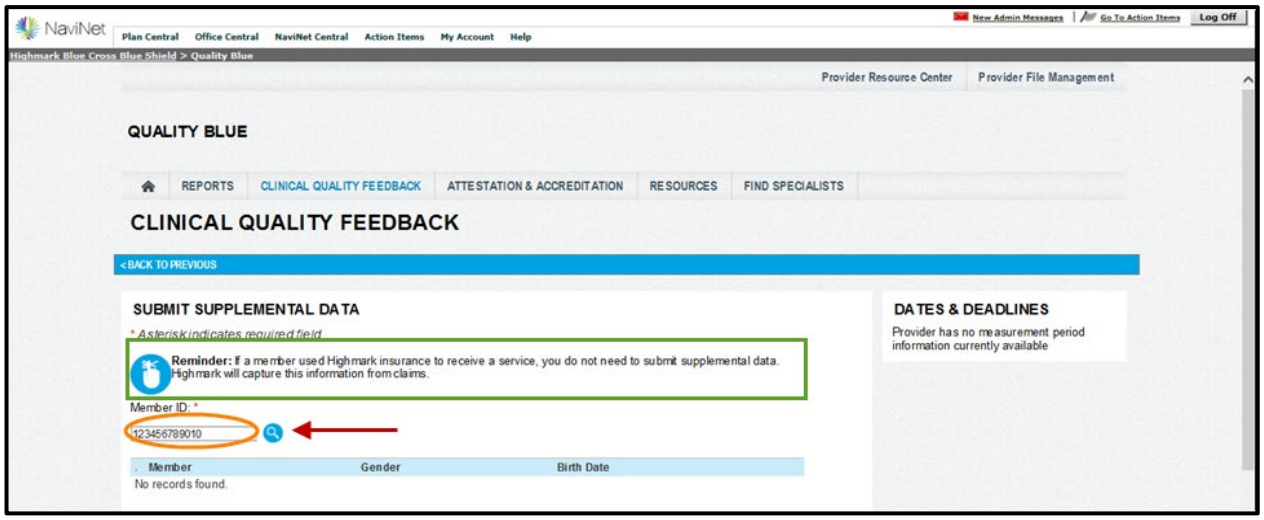

Figure 4: Member Search

First, you will locate the member for which the submission is to be made by entering the member's Highmark ID number (including all numbers and any special characters, if applicable) in the box circled in orange and click the magnifying glass (marked with the red arrow in Figure 4 on Page 6) to search for the member. All members associated with that member ID will appear on the bottom of the page. Select the appropriate member by clicking the circle next to their name. Finally, click the "Select" button at the bottom of the page. This will take you to the next page in the submission process. If provider gets "member not found" message while searching, provider should try entering the member ID with the suffix. If the member is still not found, they should contact the Clinical Transformation Consultant for assistance.

Note: When entering the member ID in the Clinical Quality Feedback function, the member ID will need to contain the prefix for Highmark and Blue Distinction Total Care members. (This does not apply to the member IDs for FEP or Medicaid members). The prefix can be found in a variety of places:

- The member's insurance card

- On NaviNet: NaviNet → Highmark → Workflows → Eligibility and Benefits → search by Name and date of birth → view current ID card. On the NaviNet ID card below the patient information and group information you will find the prefix.
- True Performance reporting: The prefix is listed on the attribution roster for every attributed member. The prefix will remain on the attribution roster, but will also be included on the patient level detail tabs of the monthly True Performance Lump Sum quality reporting.

Once you have chosen the member you wish to make a submission for, you will be taken to the final page in the process (see Figure 5 on Page 7). In order to make a submission, all fields with a red asterisk are required and need to be completed. A submission cannot be sent to Highmark without all of the required fields complete. One of the required fields for submission is an attachment of documentation from the patient's medical record to substantiate the submission. Highmark follows NCQA HEDIS® requirements for accepting the supplemental data (as outlined in the *Appendix* to this Supplemental Guide). Attached documentation can be provided in the following file formats: .bmp, .doc, .gif, .jpeg, .pdf, .png, .docx and .tif.

Note: File size is limited to 5MB. Anything over that limit will result in an error.

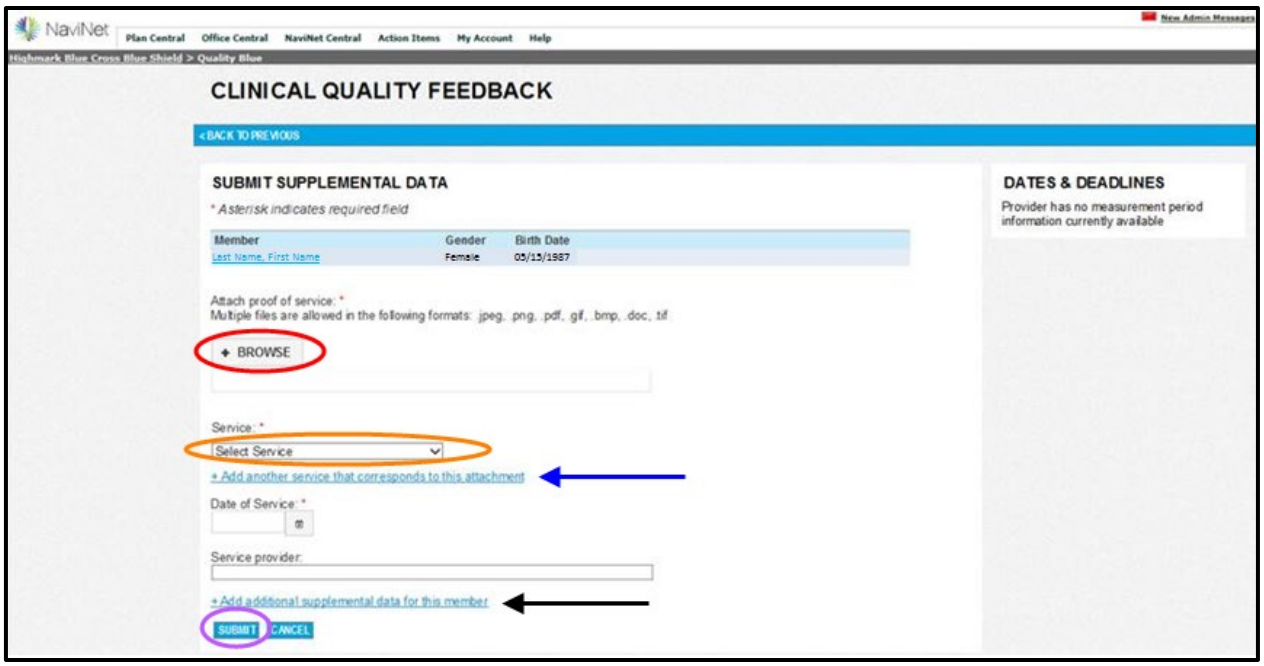

Figure 5: Submit

To attach a file, click on the “Browse” button (circled in red in Figure 5 on Page 7) which will allow you to browse your computer to locate the file(s) you want to include on the submission. Next, you will pick the service or diagnosis for which you would like to submit for the member from the drop-down menu circled in orange (required field). The final required field is to provide the date of service for the selected service (or the date in which there is proof of the disease/procedure in the attached medical record documentation).

Note: A submission cannot be made unless 30 days have lapsed since the date of service. The user will receive an error message and the submission will not be successful if the date of service is less than 30 days from the date of submission.

There is the option to include the service provider, if other than your office. This is not a required element and should not be used to provide comments on the submission.

If you have multiple services or diagnoses to submit for a member associated with the same medical record, you can click the link highlighted by the blue arrow (Figure 5 on Page 7) to get another service/diagnosis drop-down. Additionally, if you have other services/diagnoses for the same member that are associated with a different medical record, you can click the link highlighted by the black arrow (Figure 5 on Page 7). This will allow you to add another medical record and service for the same member. (There is no limit to the number of services/ diagnoses that you can submit for a member at one time.)

Once all fields are complete, click “Submit” (circled in purple in Figure 5 on Page 7) at the bottom of the screen to send your submission to Highmark for review.

Highmark reviews each submission for accuracy and completeness as per guidelines set forth by NCQA HEDIS. Each specific diagnosis and service has their own set of guidelines which are outlined in the *Appendix*. Additionally, NCQA HEDIS requires the following elements on all submissions:

- Member name
- Member date of birth
- Performing provider signature (written or electronic)

On the Clinical Quality Feedback homepage (Figure 2 on Page 4), the status of each submission (Accepted, Declined, or Pending) is displayed. Additionally, you can see if there were comments made on the submissions that Highmark has reviewed. If comments were provided, an exclamation point in an orange triangle will appear in the "Comments" column (highlighted in the purple circle in Figure 2 on Page 4). All declined submissions will be given a reason for denial and comments will be provided. Declined submissions can be updated and sent again for review and possible acceptance. Declined reasons are as follows:

- Did not meet NCQA requirements for submission
- Documentation does not match member
- Documentation does not match service submission
- Documentation doesn't match service date submitted
- Missing member identifiers in documentation
- More information needed
- Other
- Submission duplicates Highmark claims data.

A few examples of declined submissions include:

Reason Declined	Explanation
Documentation does not match member	Used if the medical record attached to the submission was for Patient A, but the submission was for Patient B.
Missing member identifiers in documentation	Used if the medical record submitted does not have the patient's name and date of birth.
Submission duplicates Highmark claims data	Used to decline a record that was submitted for a service that was already submitted to Highmark on a claim. During the review process, Highmark evaluates claims to see if the service was captured in claims. If it was, the Clinical Feedback submission will be declined.

When a submission in the Clinical Quality Feedback function is reviewed and accepted, the acceptance means that the submission contained all elements necessary to meet NCQA HEDIS supplemental documentation criteria. An acceptance does not mean that a quality gap will be closed or the member will be removed from the measure. The data captured through the Clinical Quality Feedback function is used for a variety of programs at Highmark. There are instances when the submissions will close a gap in one program but not others due to differing timeframes.

TIMELINE FOR SUBMISSIONS

Once you make a Clinical Quality Feedback submission, please allow approximately 2-3 weeks for Highmark to complete the initial review. This time period may vary based on the volume of submissions received.

Clinical Quality Feedback submissions will feed the value based reimbursement and provider incentive program quality dashboards in which you participate. Clinical Quality Feedback submissions will also feed the Cotiviti Provider Intelligence (PI) Tool which is available to some practices based on program participation. Highmark sends Cotiviti a monthly file feed for the PI Tool. Once submissions are accepted, Highmark will send the submission in the next monthly feed to Cotiviti. Depending on when your submission is accepted in comparison to when the monthly feed happens, it may take up to 2 months from the time a submission is accepted until it could impact the measures displayed in the PI Tool.

As mentioned, Clinical Quality Feedback submissions support a variety of programs including True Performance. December 31, 2022 is the deadline for submissions to be submitted, reviewed, and approved to have a possible impact on the calendar year quality assessments for True Performance and the additional incentive opportunity for Medicare Advantage Star Rating.

We hope you find the Clinical Quality Feedback function a valuable enhancement to our programs. If you have questions about the Clinical Quality Feedback function, please contact your Clinical Transformation Consultant or Provider Account Liaison.

APPENDIX

Measure	Service	Numerator Compliance (N) or Denominator Exclusion (E)	Supplemental Documentation
QN02.3: Comprehensive Diabetes Care: Medical Attention for Nephropathy [CMS Star C14]	ACE/ARB prescribed or currently being taken	N	Documentation that ACE/ARB was prescribed or is currently being taken during the measurement year.
	CKD Stage 4	N	Documentation of evidence of CKD Stage 4 during the measurement year.
	ESRD Stage 5	N	Documentation of evidence for End Stage Renal Disease (Stage 5).
	Kidney Transplant	N	Documentation of evidence of a Kidney Transplant during the measurement year.
	Nephropathy	N	Documentation of medical attention for nephropathy by a nephrologist during the measurement year.
	Nephropathy Screening Test	N	Documentation of nephropathy screening test performed during the measurement year. (i.e., urine microalbumin).
	Urine Macroalbumin Test	N	Documentation of a Macroalbuminuria test during the measurement year. Urine dip performed in the office can be submitted, regardless of result.
	Gestational Diabetes	E	Provide documentation supporting: Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes in any setting, during the measurement year or the year prior to the measurement year. **Note: If a report is not available, please include year of DOS.
	Steroid-induced Diabetes	E	Provide documentation supporting: Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year. **Note: If a report is not available, please include year of DOS.
QN02.4: Eye Exam for Patients With Diabetes [CMS Star C13]	Diabetic Retinal Screen – No result/Current year +	N	Documentation in the medical record of a retinal exam or a dilated eye exam performed during the measurement year with a positive result or no result at all.
	Diabetic Retinal Screening (prior year negative)	N	Documentation in the medical record of a negative retinal exam or a negative dilated eye exam for diabetic retinopathy performed in year

Updated: March 2022
Note: Measure specifications/details can be obtained in the masthead measure guide
Note: Program reports can be used to determine which members have an open care gap that may require a submission

Measure	Service	Numerator Compliance (N) or Denominator Exclusion (E)	Supplemental Documentation
			prior to the measurement year. **Note: If a report is not available, please include year of DOS.
	Diabetic Retinal Screening (current year negative)	N	Documentation in the medical record of a negative retinal exam or a negative dilated eye exam for diabetic retinopathy performed during the measurement year.
	Gestational Diabetes	E	Provide documentation supporting: Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes in any setting, during the measurement year or the year prior to the measurement year.
	Steroid-induced Diabetes	E	Provide documentation supporting: Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year. **Note: If a report is not available, please include year of DOS.
	Polycystic Ovarian Syndrome	E	Provide documentation supporting: Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome in any setting, during the measurement year or the year prior to the measurement year. **Note: If a report is not available, please include year of DOS.
QN08: Breast Cancer Screening [CMS Star C01]	Mammography	N	Documentation showing a mammogram screening was performed during the measurement year or the 15 months prior to the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include month and year of DOS
	Bilateral Mastectomy	E	Documentation of a bilateral mastectomy at any time prior to the end of the measurement year. Documentation of any of the following would meet criteria for bilateral mastectomy: - Bilateral mastectomy - Two unilateral mastectomies on different dates of service (enter date of service as the date of the second mastectomy). - Two unilateral mastectomies on the same date of service.

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Measure	Service	Numerator Compliance (N) or Denominator Exclusion (E)	Supplemental Documentation
			**Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
QN09: Colorectal Cancer Screening [CMS Star C02]	Colonoscopy	N	Documentation showing a Colonoscopy was done in the measurement year or nine years prior to the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
	CT Colonography	N	Documentation showing a CT Colonography was done in the measurement year or four years prior to the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
	Fecal-Occult Blood Test (FOBT)	N	Documentation showing a FOBT test was done during the measurement year. FOBT performed in an office setting or performed on a sample collected via a digital rectal (DRE) is not acceptable.
	Cologuard (FIT-DNA)	N	Documentation showing a FIT-DNA (Cologuard) test was done during the measurement year or two years prior to the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
	Flexible Sigmoidoscopy	N	Documentation showing a Flexible Sigmoidoscopy test was done during the measurement year or four years prior to the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
	Colorectal Cancer	E	Documentation of colon cancer at any time prior to the end of the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
	Total Colectomy	E	Documentation of a total colectomy at any time prior to the end of the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
QN27: Screening for Future Fall Risk [CMS Star HOS1]	Fall Risk Assessment	N	Documentation showing that patient was screened for future fall risk during the measurement year.
	Fall Risk Assessment Not Completed	E	Documentation that patient was not screened for Future Fall Risk for medical reasons (i.e., patient is not ambulatory).

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Measure	Service	Numerator Compliance (N) or Denominator Exclusion (E)	Supplemental Documentation
QN36: Hemoglobin A1c Control For Patients With Diabetes: HbA1c control (≤9%) [CMS Star C15]	HbA1c Level 7.0-7.9%	N	Documentation of an HbA1c result from the measurement year that is between 7.0-7.9%.
	HbA1c Level 8.0-9.0%	N	Documentation of an HbA1c result from the measurement year that is between 8.0-9.0%.
	HbA1c Level <7.0%	N	Documentation of an HbA1c result from the measurement year that is less than 7.0%.
	HbA1c Value >9.0%	N	Documentation of an HbA1c result from the measurement year that is greater than 9.0%.
	Gestational Diabetes	E	Provide documentation supporting: Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes in any setting, during the measurement year or the year prior to the measurement year.
	Steroid-induced Diabetes	E	Provide documentation supporting: Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
	Polycystic Ovarian Syndrome	E	Provide documentation supporting: Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome in any setting, during the measurement year or the year prior to the measurement year. **Note: If a report is not available, please include year of DOS.
QN43: Osteoporosis Management in Women Who Had a Fracture [CMS Star C12]	Bone Mineral Density Test	N	Documentation of a bone mineral density test that was performed on the day of the fracture or up to 180 days after the fracture. **Note: If DOS is not during measurement year and a report is not available, please include month and year of DOS.
	Osteoporosis Therapy	N	Documentation of an osteoporosis therapy dispensed by a pharmacy or sample provided on the day of the fracture or up to 180 days after the fracture. If the prescription was picked up at a **Pharmacy**, documentation must include all of the following: - Generic name of the drug

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Note: Measure specifications/details can be obtained in the masthead measure guide
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Measure	Service	Numerator Compliance (N) or Denominator Exclusion (E)	Supplemental Documentation
			- Strength/dose - Route - Date when the medication was received by the member **Note: A receipt from the pharmacy will contain all of the required elements If a **sample** was provided, documentation must include all of the following: - Route - Lot number - Expiration date - Generic medication name - Quantity - Strength - Date medication was received by the member **Note: Generic documentation in the medical record (e.g., that a patient was "given" or "prescribed" or "actively taking" an osteoporosis medication) that does not include the elements listed above does not meet criteria.
	Bone Mineral Density Test	E	Documentation of a bone mineral density test that was performed up to 2 years prior to the fracture. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
	Osteoporosis Therapy	E	Documentation of an osteoporosis therapy dispensed by a pharmacy or sample provided on the day of the fracture or up to 12 months prior to the fracture. If the prescription was picked up at a **Pharmacy**, documentation must include all of the following: - Generic name of the drug - Strength/dose - Route - Date when the medication was received by the member **Note: A receipt from the pharmacy will contain all of the required elements If a **sample** was provided, documentation must include all of the following: - Route - Lot number - Expiration date

Measure	Service	Numerator Compliance (N) or Denominator Exclusion (E)	Supplemental Documentation
			- Generic medication name - Quantity - Strength - Date medication was received by the member **Note: Generic documentation in the medical record (e.g., that a patient was "given" or "prescribed" or "actively taking" an osteoporosis medication) that does not include the elements listed above does not meet criteria.
QN64: Statin Therapy for Patients with Cardiovascular Disease [CMS Star C22]	Cirrhosis	E	Documentation of cirrhosis during the measurement year or the year prior to the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
	ESRD	E	Documentation of end stage renal disease (ESRD) during the measurement year or the year prior to the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
	Myalgia	E	Documentation of myalgia during the measurement year.
	Myopathy	E	Documentation of myopathy during the measurement year.
	Pregnancy	E	Documentation of pregnancy during the measurement year or the year prior to the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
	IVF	E	Documentation of in-vitro fertilization (IVF) in the measurement year or the year prior to the measurement year. **Note: If DOS is not during measurement year and a report is not available, please include year of DOS.
QN76: Controlling High Blood Pressure [CMS Star C16]	Diastolic BP 80-89	N	Documentation of diastolic BP 80-89 during the measurement year.
	Diastolic BP ≥90	N	Documentation of diastolic BP ≥90 during the measurement year.
	Diastolic BP <80	N	Documentation of diastolic BP <80 during the measurement year.
	Systolic BP ≥140	N	Documentation of systolic BP ≥140 during the measurement year.

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Measure	Service	Numerator Compliance (N) or Denominator Exclusion (E)	Supplemental Documentation
	Systolic BP 130-139	N	Documentation of systolic BP of 130-139 during the measurement year.
	Systolic BP <130	N	Documentation of systolic BP <130 during the measurement year.
	Nursing service/pharmacy visit	N	Documentation of a nursing service (that was not billed) or pharmacy visit during the measurement year.
	Specialist Office Visit	N	Documentation of a Specialist Office Visit during the measurement year.
QN91: Transitions of Care: Medication Reconciliation Post-Discharge [CMS Star DMC19]	Medication Reconciliation	N	Documentation in the outpatient medical record must include evidence of medication reconciliation post inpatient discharge and the date when it was performed. Any of the following meets criteria: - Documentation that the current and discharge medications were reconciled. - Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications). - Documentation of the member's current medications with a notation that the discharge medications were reviewed. - Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service. - Notation that no medications were prescribed or ordered upon discharge. **Note: Only documentation in the outpatient medical record meets the criteria. However, an outpatient visit is not required.
QN92: Transitions of Care: Patient Engagement After Inpatient Discharge [CMS Star DMC21]	Nursing Service/Pharmacy Visit	N	Documentation in the outpatient medical record must include evidence of a nursing visit (that was not billed) within 30 days after inpatient discharge.
	Telephone Visit	N	Documentation in the outpatient medical record must include evidence of a telephone visit within 30 days after inpatient discharge.
	Synchronous Telehealth Visit	N	Documentation in the outpatient medical record must include evidence of a synchronous telehealth visit where a real-time interaction occurred between the member and provider using audio and video communication.

Measure	Service	Numerator Compliance (N) or Denominator Exclusion (E)	Supplemental Documentation
	E-Visit/Virtual Check-In	N	Documentation in the outpatient medical record must include evidence of an e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider) within 30 days after inpatient discharge.
QN93: Follow Up After ED Visit for People with Multiple Chronic Conditions [CMS Star DMC18]	Nursing Service/Pharmacy Visit	N	Documentation in the medical record must include evidence of a nursing visit (that was not billed) within 7 days of the ED visit.
	Complex Care Management Services	N	Documentation in the medical record must include evidence of a complex care management service within 7 days of the ED visit.
	Telephone Visit	N	Documentation in the medical record must include evidence of a telephone visit within 7 days of the ED visit.
	E-Visit/Virtual Check-In	N	Documentation in the medical record must include evidence of an e-visit or virtual check-in within 7 days of the ED visit.
	Case Management Visit	N	Documentation in the medical record must include evidence of a case management visit within 7 days of the ED visit.
QN96: Kidney Health Evaluation for Patients with Diabetes [CMS Star DMC14]	Estimated Glomerular Filtration Rate	N	Documentation of an estimated glomerular filtration rate lab test (eGFR) during the measurement year.
	Polycystic Ovarian Syndrome	E	Documentation of polycystic ovarian syndrome during the measurement year or the year prior.
	Steroid-induced Diabetes	E	Documentation of steroid-induced diabetes during the measurement year or the year prior.
	Gestational Diabetes	E	Documentation of gestational diabetes during the measurement year or the year prior.
	ESRD	E	Documentation of evidence for End Stage Renal Disease anytime during the member's history on or prior to the end of the measurement year.