**Addendum I – Analyst Supplement**

**Colorado All Payer Claims Database Application**

**Project Description and Data Objective**

Project Title and number: *(matches Project Title on CO APCD Application)*

**Date Range or Years Requested** – *What years of claims do you need to meet your project purpose? (If you want a range of data with specific month and day start and end dates, please supply the start and end dates next to the appropriate year.)*

Check all that apply:

2009\*

2010\*

2011\*

2012

2013

2014

2015

2016

2017

2018

**Medicare FFS data:** Data requests are only available for research purposes and must be approved and financially supported by HCPF.

Check all that apply:

2009\*

2010\*

2011\*

2012

2013

2014

2015

2016

\***Please Note:** Data available from 2009-2011 is less robust than 2012-current. Please contact your Account Executive if you have questions.

**Lines of Business:** *Which payers do you need for your project purpose?*

Please check all that apply

**Commercial Payer Claims** - Data available with appropriate levels of aggregation

Need to discuss appropriate level of aggregation for client request type; would need analyst input

**Individual**

**Small Group Plans**

**Large Group Plans**

* + - ***Currently available:*** Medical Claims AND Pharmacy Claims from 2009- June 2017
      * **Claims**
      * **Eligibility**
      * **Servicing and Billing Provider information**

**Fully insured Employer Plans**

**Self-Insured ERISA and non-ERISA based Employer Plans (note: ERISA-based plans are voluntary submitters and are not all represented in the CO APCD)**

* + - ***Currently available:*** Medical Claims AND Pharmacy claims from 2015- June 2017
      * **Claims**
      * **Eligibility**
      * **Servicing and Billing Provider information**

**Medicare Advantage** - data is available with appropriate levels of aggregation

Need to discuss appropriate level of aggregation for client request type; would need analyst input

* + - ***Currently available:*** Medical AND Pharmacy claims from 2015- June 2017
      * **Claims**
      * **Eligibility**
      * **Servicing and Billing Provider information**

**Health First Colorado (Colorado’s Medicaid Program)** - Data requests must be reviewed by the Colorado Department of Health Care Policy and Financing (HCPF) to ensure alignment with administration of the Medicaid program as required by federal law

* + - ***Currently available:*** Medical Claims AND Pharmacy Claims from 2009- February 2017
      * **Claims**
      * **Eligibility**
      * **Servicing and Billing Provider information**

**The following lines of business, when requested, require CIVHC Data Release Review Committee review as well as HCPF review, approval, and financial support.**

**Medicare Fee For Service (FFS) -** Data requests are only available for research purposes and must be approved and financially supported by HCPF.

* + - ***Currently available:*** Medical Claims AND Pharmacy Claims from 2009-2015
      * **Claims**
      * **Eligibility**
      * **Servicing and Billing Provider information**

**Payer-Specific Details** – Do you need to limit claims to particular health insurance coverage types?

**Yes**

**No**

* **If YES,** please indicate the specific information you would like to include:
  + **Payer Line of Business**

**Commercial**

* + - * **Payer Name: Please note Anti-trust guidelines will be followed. (DRRC review maybe also be required)** 
        + *Please provide listing of payer names and health plans*
      * **Commercial Product Line(s):**

**PPO**

**HMO**

**POS**

**Supplemental**

**Indemnity**

**Other- Please specify**

* *Please provide listing of other product lines*

**Colorado’s Exchange, Connect for Health Colorado, Product Lines**:

**Gold**

**Silver**

**Bronze**

**Payment Type** – *Which elements of total paid amount on each claim do you need to support your project purpose? (Check all that apply)*

**Charged Amount**

**Plan Paid Amount\***

**Member Liability, i.e., amount the member is responsible for (check all that apply)**

**Coinsurance**

**Deductible**

**Copay**

**Total Allowed Amount** – (summation of plan paid and member liability)

**Prepaid Amount** – (*to be considered for capitated payment plans only*)

**Medical Claims** – *Which types of claims do you need for your project purpose?*

* Check all that apply

**Inpatient (IP)** – Related to individuals who receive care in hospital settings

**Outpatient (OP)** – Related to an individual receiving medical treatment in any setting other than a hospital admission (i.e. ambulatory surgery center; doctor’s office, imaging center, Emergency Room, home health, etc.)

**Professional (PROF)** – Related to medical procedures within professional settings (e.g. physician office, imaging center, etc.) and clinics

**Pharmacy Claims** – *Do you need prescription drug-based claims for your project purpose?*

**Yes**

**No**

* **If YES**, and you need pharmacy claims limited to specific drug types, ***please list the 11-digit NDC codes you would like to receive (DO NOT INCLUDE DASHES AND PROVIDE LEADING ZEROS):***
  + - *Please provide listing*

**Dental Claims** – *Do you need dental claims for your project purpose?*

**Yes**

**No**

**Site of Service Detail** – *Do you need to look at claims that occurred in specific care settings for your project purpose? i.e., do you need to limit services by site of service?*

**Yes**

**No**

* **If YES,** please indicate the specific information you would like to include:

**Hospital**

**Ambulatory Surgery Centers**

**Outpatient Facilities**

**Physician offices**

**Specialty offices**

**Home Health**

**Urgent Care**

**Emergency Room (Note: cannot differentiate between majority of Free-Standing and hospital-based ERs)**

**Other** (specify)

* + - *Please list other site of service details*

**Provider-level Detail** – *Do you need claims limited to specific providers or provider type(s) ie. (Provider IDs, locations, hospitals, medical groups, etc.) for your project purpose?*

**Yes**

**No**

* **If YES,** please indicate the specific provider types you would like to include or provide a list of providers:

**Facilities (hospitals, ambulatory surgery centers, etc.)**

* + - *Please provide listing*

**Professionals**

* + - *Please provide listing*

**Provider Taxonomy** - **Specialty Designations**

* + - *Please provide listing*

**National Provider Identifier**

* + - *Please provide listing*

**Other**

* + - *Please provide listing*

**Geography**– *Do you need claims data limited by geography or location for your project purpose?*

**Yes**

**No**

* **If YES,** please indicate the geographic groupings you would like to include:

**Provider location address**

* + - *Please provide listing*

**Member location address**

* + - *Please provide listing*

**Zip 3**

* + - *Please provide listing*

**Health Statistic Region**

<http://www.cohid.dphe.state.co.us/brfssdata.html>

* + - *Please provide listing*

**County (Potential PHI)**

* + - *Please provide listing*

**Zip 5** (**PHI**)

* + - *Please provide listing*

**Other**

* + - *Please provide listing*

**Age and/or Gender** – *Do you need claims data limited by age or gender for your project purpose?*

**Yes**

**No**

* **If YES,** please indicate the groupings you would like to include:

**Age bands/range (in years) requested (i.e. 0-21, 22-39, 40-55, etc.)**

*Please specify specific bands and/or ranges*

*Please specify how you would like age to be calculated (i.e. Patient age at the end of year, at the time of service, etc.)*

**Gender**

**Male**

**Female**

**Unspecified**

**Member-level Detail** – *Do you need claims filtered at the member level for your project purpose?* *i.e.,* *do you need claims limited to specific members for your project?*

**Yes**

**No**

* **If YES,** please indicate the information you would like to include:

**De-identified member information**

**Unique member and person ID**

**Gender**

**Age: (at time of service)**

**3-digit zip**

**Protected Health Information (PHI)** – Any of the below requires DRRC approval process

**Names (first, last, middle) (PHI)**

**Street Address (PHI)**

**City (PHI)**

**Zip (PHI)**

**DOB (PHI)**

**Diagnosis Detail** – *Do you need claims limited to a specific diagnosis or multiple diagnoses for your project purpose?*

**Yes**

**No**

* **If YES,** please indicate the specific diagnosis code(s) you would like to include (DO NOT USE DECIMAL POINTS AND DO NOT REMOVE LEADING AND TRAILING ZEROS):
  + *Please provide listing*

**Procedure/Revenue Code Detail** – *Do you need claims limited to specific procedure or revenue code(s) for your project purpose?*

**Yes**

**No**

* **If YES,** please indicate the specific procedure/revenue code(s) you would like to include under each type requested:

**CPT4**

*Please provide listing*

**CDT**

*Please provide listing*

**Revenue code**

*Please provide listing*

**APR-DRG**

*Please provide listing*

**ICD9 or ICD10**

**(Please indicate whether the codes you provide are ICD 9 or 10 codes)**

*Please provide listing*

**Additional Requests/Info Not Included Above**– *Is there any additional information you would like for us to know to fulfill your request?*

* *Please list additional request for information below.*

By signing this Agreement, the Receiving Organization agrees to abide by all provisions set out in this Agreement.

**SIGNATURES:**

**For the APCD: For Receiving Organization:**

**Signature: Signature:**

**Name: Pete Sheehan Name:**

**Title: VP of Business Development Title:**