

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)*

22.30 OnPoint Medical Group – Specialty Referral Network Development (Geographical Area and NDX codes to be received)**

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:

- ☐ 2012
- ☐ 2013
- ☐ 2014
- ☐ 2015
- ☐ 2016
- ☐ 2017
- ☐ 2018
- ☒ 2019
- ☒ 2020
- ☒ 2021*

*Please consult the Data Warehouse refresh schedule or with your Health Data Solutions Consultant to learn what is currently available for 2021

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

Check all that apply:

- ☐ 2012
- ☐ 2013
- ☐ 2014
- ☐ 2015
- ☐ 2016
- ☐ 2017
- ☐ 2018
- ☐ 2019
- ☐ 2020

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 2012-2020
 - 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
 - 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 2012-2020
 - 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 2012-2020
 - 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 2012-2018
 - 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) i.e. (Provider IDs, locations, hospitals, medical groups, etc.) for your project purpose?

☐ Yes

☒ No **include but not limit**

- 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**
 - Need full address of all providers in CO
- ☐ **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)
 - ☒ 5 Digit Zip (PHI) **Include, not filter by**
 - ☐ DOB-Dates of Birth (PHI)
 - ☐ DOS-Dates of Service (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

Acknowledgement of Review and Approval of the Data Elements Dictionary that Accompanies the Project-

Initials: _____

DED filename and/or version number: _____

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

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

SIGNATURES:

For the CO APCD:	For Receiving Organization:
Signature:	Signature:
Name: Pete Sheehan	Name:
Title: VP of Client Solutions & State Initiatives	Title: