CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Addendum I – Analyst Supplement
Colorado All Payer Claims Database Application

Project Description and Data Objective

Project Title and number: 22.52 The cost and treatment of epilepsy

The overarching goal of our project is to estimate the costs incurred and treatments received by patients with epilepsy and/or seizure.

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*

*Please consult the Data Warehouse refresh schedule to learn what is currently available for 2020

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

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) 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**
    - *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**
    - ☒ **DOB-Dates of Birth (PHI) *include**
    - ☒ **DOS-Dates of Service (PHI) *include**

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

☒ **Yes**

☐ **No**

NOTE: We can work with the entire database, but if that is not possible, we would like a data set with claims for patients with epilepsy (codes below) and a sample of "control" enrollees without epilepsy.

- **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):

- Primary Diagnosis Code (ICD-9) = 34550, 34550, 34551, 34551,34550, 34570, 34580,34550, 34570, 34580,34551, 34571, 34581, 34551, 34571, 34581, 34540,34540,34541,34541,3452, 3453,34500, 34510,34501, 34511, 3452, 3453, 34501, 34511, 3452, 3453, 34560, 34560,34561,34561,34580, 34580, 34580, 34580, 34581, 34581, 34581, 34580, 34581, 34581, 34580, 34580, 34581, 34581, 34580, 34581, 34590, 34590, 34591, 34591, 34580, 34580, 34581, 34581, 34580, 34580, 34581, 34581, 78031, 78032, 78033, 78039
- Primary Diagnosis Code (ICD-10) = G40, G400, G40001, G40009, G4001, G40011, G40019, G4009, G401, G4010, G40101, G40109, G4011, G40111, G401111, G40119, G4019, G402, G4020, G40201, G40209, G4021, G40211, G40219, G4022, G40290, G403, G4030, G40301, G40309, G4031, G40311, G40319, G4039, G404, G4040, G40401, G40406, G40409, G4041, G40411, G40419, G405, G40501, G40509, G406, G408, G4080, G40801, G40802, G40803, G40804, G4081, G40811, G40812, G40813, G40814, G4082, G40821, G40822, G40823, G40824, G40833, G40834, G4089, G409, G4090, G40901, G40909, G409090, G409091, G4091, G40911, G40919, G40949, G4099, G40991, G40A, G40A0, G40A01, G40A09, G40A11, G40A19, G40B, G40B0, G40B01, G40B09, G40B11, G40B19, R56, R560, R5600, R5601, R561, R5669, R5681, R569, or R5691

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 (SEE ABOVE)**
    (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?*

- Claims for enrollees with at least one claim listing a diagnosis code for epilepsy and/or seizure – are looking for a cost for those who have epilepsy as compared of those patients who don't have epilepsy (random sample).
- Claims for a control group of enrollees who do not have claims listing diagnosis codes for epilepsy and/or seizure

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:** David H. Howard
Title: VP of Client Solutions & State Initiatives	**Title: Professor**