Addendum I – Analyst Supplement
Colorado All Payer Claims Database Application

Project Description and Data Objective

Project Title and number: 21.85 SEARCH for Diabetes in Children and Young Adults 0-45 years (SEARCH-DiCAYA) Diabetes Surveillance Study

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
- ☐ 2019

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:
  - o **Payer Line of Business**
    - ☐ **Commercial**
      - **Payer Name: Please note Anti-trust guidelines will be followed. (DRRC review maybe also be required)**

o *Please provide listing of payer names and health plans*

- **Commercial Product Line(s):**
  - ☐ **PPO**
  - ☐ **HMO**
  - ☐ **POS**
  - ☐ **Supplemental**
  - ☐ **Indemnity**
  - ☐ **Other- Please specify**
    - o *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* We are working on getting these.

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
      0 – 45 years
      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.)
      Patient age at the end of the year

  ☐ **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: Please see case definition in additional information section
    - ☐ **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)**
        - ☐ **DOB-Dates of Birth (PHI)**
        - ☐ **DOS-Dates of Service (PHI)**

<u>Diagnosis Detail</u> – *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*

<u>Procedure/Revenue Code Detail</u> – *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?*

We have formulated the following eligibility criteria to identify individuals that should be included in the dataset. We would like *all encounter* data from 2012-2020 for those that meet the case definition below.

Diabetes Likelihood based on diabetes qualifying encounters occurring between January 1, 2017-December 31, 2020:
- Any diabetes qualifying ICD-9-CM (250.xx, 775.1, 648.0x, 357.2, 362.0x, 366.41) or ICD-10-CM (E10-E14, P70.2, O24.3xx, O24.9xx)
  OR
- Any diabetes qualifying lab results (HbA1c >= 6.0% (42 mmol/mol), OR random blood glucose >= 200 mg/dL, OR fasting blood glucose >= 126 mg/dL)
  OR
- Any diabetes qualifying medication prescription or dispensing: (We are working on getting NDC codes for these medications.)
    - Glyburide
    - Gliclazide
    - Glipizide
    - Glimepiride
    - Pioglitazone
    - Rosiglitazone
    - Repaglinide
    - Nateglinide
    - Meglitinide
    - Sitagliptin
    - Exenatide
    - Pramlintide
    - Insulin
    - Glucagon
    - Metformin
    - Sulfonylurea
    - Thiazolidinediones
    - Acarbose

AND
- Date of birth must be between January 1, 1967 – December 31, 2020

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: *Tessa Crume*
Name: Pete Sheehan	Name: Tessa Crume
Title: VP of Client Solutions & State Initiatives	Title: SEARCH-DiCAYA Co-PI, Associate Professor