Assessment for Quality Improvement and Risk Evaluation Tool

Version 8.0

Data Preparation Guide

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DATA PREPARATION AND REQUIRED FORMATS

The first step in preparing data for the Assessment for Quality Improvement and Risk Evaluation Tool is to identify a relevant patient population based on the type(s) of claims data available. This Tool was designed to evaluate patients with Schizophrenia or Bipolar I Disorder; both pharmacy and medical claims data are required to take advantage of the full functionality of the Tool. If only pharmacy claims are available, the population cannot be limited to patients with Schizophrenia or Bipolar I Disorder; however, the Tool can conduct a more limited number of analyses among all patients receiving antipsychotic medications.

It is recommended that at least 12 months of claims for only the relevant patient population be loaded into the Tool.

- If both medical and pharmacy claims are available, the population should be limited to all patients with Schizophrenia or adults with Bipolar I Disorder (i.e., patients with 1 inpatient or 2 outpatient medical claims indicating an ICD-9-CM diagnosis code of 295.xx/ICD-10-CM diagnosis code of F20.xx-F29.xx for Schizophrenia or an ICD-9-CM diagnosis code of 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, or 296.7x/ICD-10-CM diagnosis code of F30.xx-F31.xx (excluding F31.81 and F30.9), F32.8 for Bipolar I Disorder).
    - Note that ICD code type (i.e., 9 or 10) does not need to be specified by the user. The Tool will automatically read either format for diagnosis and procedure codes
- If only pharmacy claims are available, then all patients treated with antipsychotic medications should be identified. The medical claims file should include all types of medical claims (e.g., hospital inpatient, hospital outpatient, provider).

The variables in the pharmacy and medical claims datasets must be prepared according to the specification below. **The datasets must then be exported to a tab-delimited text file (with no string enclosure), and placed in the folder located at: "C:\Program Files\QI-RE\sample_claims".** It is recommended that the first line of the text files contain the field names for each variable that are specified in Table 1 and Table 2 below. This will ensure that the Source and Destination fields match, improving the efficiency of the data import process.

Table 1. Variables for pharmacy claims

Field Name	*Data Type*	*Length*	*Format*	*Required*
Age	Numeric	No restriction	N/A	Yes
Days Supplied	Numeric	No restriction	N/A	Yes
Dispense Date	Text	10	yyyy-mm-dd	Yes
NDC Code	Text	11	NDC code	Yes
Patient ID	Text	No restriction	N/A	Yes
Provider ID	Text	No restriction	N/A	Yes

Table 2. Variables for medical claims

Field Name	*Data Type*	*Length*	*Format*	*Required*
Age	Numeric	No restriction	N/A	Yes
Amount	Numeric	No restriction	N/A	No
Diagnosis Code 1	Text	5	ICD-9/10 Code	Yes
Diagnosis Code 2	Text	5	ICD-9/10 Code	No
Diagnosis Code 3	Text	5	ICD-9/10 Code	No
Diagnosis Code 4	Text	5	ICD-9/10 Code	No
Diagnosis Code 5	Text	5	ICD-9/10 Code	No
Diagnosis Code 6	Text	5	ICD-9/10 Code	No
Diagnosis Code 7	Text	5	ICD-9/10 Code	No
Diagnosis Code 8	Text	5	ICD-9/10 Code	No
Header Record	Numeric	1	0 = no; 1 = yes	No
Patient ID	Text	No restriction	N/A	Yes
Procedure Code 1	Text	5	HCPCS or ICD-9/10 Code	Yes
Procedure Code 2	Text	5	HCPCS or ICD-9/10 Code	No
Procedure Code 3	Text	5	HCPCS or ICD-9/10 Code	No
Procedure Code 4	Text	5	HCPCS or ICD-9/10 Code	No
Service End Date	Text	10	yyyy-mm-dd	Yes
Service Start Date	Text	10	yyyy-mm-dd	Yes
Service Type	Numeric	1	0 = outpatient; 1 = inpatient; 2 = ER	Yes

Note: ICD-9/10 codes included in the imported data file should have no decimal places (e.g., 296.00 = 29600).
Note: For services provided on the same day, the end date should be set equal to the start date.

Please note the following for the Age and Header Record variables:

- Age must be calculated as of the first claim loaded for any patient in the imported claims (e.g., if you loaded claims from 2010-01-01 through 2010-12-31, you would calculate the age for every patient as of 2010-01-01).
- If you are importing the Amount field, it is necessary to specify whether or not each claim is a header record via the Header Record indicator. A header record is a claim record that contains the sum of the costs for the entire encounter (e.g., inpatient encounter has multiple records for procedures, each containing its own payment). For such records, the Header Record indicator field should be set to a 1, and all other records within that encounter should have a Header Record indicator set to 0.