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Description automatically generated

# Application for Statistical Requests

# Instructions:

The Health Services Cost Review Commission (“HSCRC,” or “Commission”) provides custom aggregate or statistical datasets for public use (“Statistical Requests”). Per the HSCRC Data Request Policy, cells containing ten (10) observations or less, or information deemed sensitive by the HSCRC (e.g., data related to substance abuse or abortion services) will not be reported to protect the identity of patients.

All information requested below must be provided to process the Statistical Requests in a timely manner​​​. Incomplete requests will not be processed. Please allow four (4) weeks for HSCRC staff to review and complete your request. **If the resources are not readily available, staff may refer your request to our data processing vendor (processing fees may apply).**

Return the completed Application and Table Shell (Appendix 1) via email to:

[**hscrc.data-requests@maryland.gov**](mailto:hscrc.data-requests@maryland.gov)**​​**

## **Requestor Information**

Date of Request: Click or tap to enter a date.

Name of Requestor or Organization:Click or tap here to enter text.

Is this an individual or an organization requesting this information?  Individual  Organization

If the Requestor is an organization, are you an Authorized Representative of the organization making this request? Yes  No

If no, please name the Authorized Representative: Click or tap here to enter text.

*(The Authorized Representative must sign the request below)*

Requestor Address: Click or tap here to enter text.

City: Click or tap here to enter text. State: Choose an item. Zip Code: Click or tap here to enter text.

Email: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

## **Analysis Information**

1. Purpose of Request:Please **fully describe** the reason or goal for the statistical analysis requested.

*Example: ACME family services is requesting information on the average length of stay and charge of adolescents seeking care for asthma for FY 2019. The information will be used for a grant application.*

Click or tap here to enter text.

1. Time Period Requested. Please also indicate whether full years (calendar (CY) or fiscal (FY)) or quarters are required. Data is available from CY 2008.

Click or tap here to enter text.

1. Data Source:  Inpatient  Outpatient (includes Observation, ED, Clinic, and Ambulatory Surgery)
2. Please describe the **analysis required and include a table shell (Appendix 1)** displaying the format of the output.

Click or tap here to enter text.

1. If requesting information on a diagnosis or procedure, please specify all codes that are required for the analysis. If using ICD-9/10 or CPT/HCPCS codes, information will be provided based on patients with the following criteria in the principal or primary category only, unless otherwise described in #1.
2. Please specify the following applicable codes for Inpatient Data:

ICD-9 diagnostic and/or procedure codes (prior to October 2015):

Click or tap here to enter text.

ICD-10 diagnostic and/or procedure codes (post October 2015):

Click or tap here to enter text.

APR DRGs:

Click or tap here to enter text.

1. Please specify the following applicable codes for Outpatient Data:

ICD-9 diagnostic codes (prior to October 2015):

Click or tap here to enter text.

ICD-10 diagnostic codes (post October 2015):

Click or tap here to enter text.

CPT or HCPCS procedure codes:

Click or tap here to enter text.

## **Population Filters**

The requested analysis can be filtered by the additional parameters below. If the request does not require a filter, please check here:  No Filters Applied

By age group or range. Specify: Click or tap here to enter text.

By payers. Check all that apply.

Medicare (Fee-for-Service and Managed Care)  Commercial

Medicaid (Fee-for-Service and Managed Care)  Other:

Click or tap here to enter text.

By patient state, county, or zip code of residence. Specify: Click or tap here to enter text.

By Hospital or Hospital System. Specify Hospital or System: Click or tap here to enter text.

By location of Hospital (County or Region). Specify location: Click or tap here to enter text.

By other filters. Specify other filters of interest: Click or tap here to enter text.

This request involves non-confidential information that was derived from the HSCRC Statewide Confidential Hospital Inpatient Discharge Data Sets (Inpatient) and/or the Hospital Outpatient Data Sets (Outpatient), collected by the Health Services Cost Review Commission (“HSCRC,” or “Commission”) under COMAR 10.37.06 and COMAR 10.37.04 respectively. The undersigned gives the following assurances with respect to the analyses (“the Analyses”) provided by the HSCRC in response to the Statistical Request described above:

* The Analyses provided by the HSCRC will only be used for the purposes identified above as approved by the HSCRC.
* All reports based on these Analyses, either by direct cite (where space and/or publication guidelines permit), or by inclusion in a list of data contributors available upon request, will indicate that the source is the HSCRC;
* All reports produced based on the Analyses that contain 3M Grouper code-level data will contain the following written notice: **“THIS REPORT WAS PRODUCED USING PROPRIETARY COMPUTER SOFTWARE CREATED, OWNED AND LICENSED BY THE 3M COMPANY. FURTHER DISTRIBUTION OF REPORTS THAT CONTAIN PATIENT AND/OR CODE LEVEL DATA IS NOT PERMITTED WITHOUT ADVANCED WRITTEN APPROVAL BY 3M. ALL COPYRIGHTS IN AND TO THE 3MTM SOFTWARE (INCLUDING THE SELECTION, COORDINATION AND ARRANGEMENT OF ALL CODES) ARE OWNED BY 3M. ALL RIGHTS RESERVED.”**

**Requestor or Authorized Representative of Requesting Organization**

My signature indicates agreement with the above statement. I understand that failure to comply with the provisions specified herein may also result in denial of access to HSCRC data in the future.

Signed: Date:

Print Name: Click or tap here to enter text. Title: Click or tap here to enter text.

**HSCRC Representative**

Signed: Date:

Print Name: Click or tap here to enter text. Title: Click or tap here to enter text.

# Appendix 1: Table Shell

Please include a table shell displaying the expected format for the layout. Please list all column and row headings. Applications that do not include a table shell will not be processed.