

IDENTIFICATION OF PATIENTS WITH CKD USING MEDICARE DATA: INPATIENT VS. OUTPATIENT CLAIMS. David T. Gilbertson<sup>1</sup>, Tricia Roberts<sup>1</sup>, Thomas Arneson<sup>1</sup>, Stephan Dunning<sup>1</sup>, Allan Collins<sup>1</sup>, Brian Bradbury<sup>2</sup>. 1Chronic Disease Research Group, Minneapolis, MN, USA. 2Amgen, Thousand Oaks, CA, USA.

Use of Medicare claims for analyses of pts with chronic kidney disease (CKD) is common. A commonly used method to identify these pts requires  $\geq 1$  inpatient claim (IP) or  $\geq 2$  outpatient (OP) claims with CKD as a diagnosis code. Although this method was developed for identification of diabetes, it, and similar approaches have been used for identifying CKD and other comorbid conditions. It is relatively unknown, however, how analyses investigating outcomes in these pts are affected by the approach used to identify patients; in particular, the source of the diagnosis (IP vs. OP) code.

We used the Medicare 5% sample for 2001 to identify pts with CKD using the method described above. We analyzed overall 1-year and interval mortality rates (0-3, 4-6, and 7-12 months after start of follow-up), by source of CKD diagnosis (IP vs. OP).

The 1-year mortality rate for pts identified from an IP code was 434/1,000 person-yrs vs. 247/1,000 person-yrs for those identified from  $\geq 2$  OP codes. This difference was strongest during follow-up months 0-3 but persisted throughout the year (figure).

Analyses of claims-identified CKD patients should take into account the source of the CKD code, because the hazard for mortality differs greatly based on source. The source of the CKD diagnosis code may be correlated with treatment exposures of interest in a statistical model, and failure to account for this correlation may lead to spurious results.

