Disclaimer

The following report(s) provides findings from an FDA-initiated query using Sentinel. While Sentinel queries may be undertaken to assess potential medical roduct safety risks, they may also be initiated for various other reasons. Some examples include determining a rate or count of an identified health outcome of interest, examining medical product use, exploring the feasibility of future, more detailed analyses within Sentinel, and seeking to better understand Sentinel capabilities.

Data obtained through Sentinel are intended to complement other types of evidence such as preclinical studies, clinical trials, postmarket studies, and adverse event reports, all of which are used by FDA to inform regulatory decisions regarding medical product safety. The information contained in this report is provided as part of FDA's commitment to place knowledge acquired from Sentinel in the public domain as soon as possible. Any public health actions taken by FDA regarding products involved in Sentinel queries will continue to be communicated through existing channels.

FDA wants to emphasize that the fact that FDA has initiated a query involving a medical product and is reporting findings related to that query does not mean that FDA is suggesting health care practitioners should change their prescribing practices for the medical product or that patients taking the medical product should stop using it. Patients who have questions about the use of an identified medical product should contact their health care practitioners.

The following report contains a description of the request, request specifications, and results from the modular program run(s).

If you are using a web page screen reader and are unable to access this document, please contact the Sentinel Operations Center for assistance at info@sentinelsystem.org.

Overview for Request: cder_mpl1r_wp178

Request ID: cder_mpl1r_wp178_nsdp_v01

Request Description: In this request we investigated insulin billing code patterns in the Sentinel Distributed Database (SDD).

Sentinel Routine Querying Module: Cohort Identification and Descriptive Analysis (CIDA) module, version 9.3.0

Data Source: We distributed this request to 16 Sentinel Data Partners on March 17, 2020. The study period included data from January 1, 2013 through December 31, 2018. Please see Appendix A for a list of dates of available data for each Data Partner.

Study Design: We identified individuals with evidence of incident and prevalent insulin use among a cohort who were 18 years of age or older. We then characterized use and dispensing patterns by examining all episodes of use occurring after the initial exposure. We also provide data on the reasons each exposure episode was censored. This is a Type 5 analysis in the Query Request Package (QRP) documentation.

Exposure of Interest: We defined the exposure of interest, insulin, using National Drug Codes (NDCs) and Healthcare Common Procedure Coding System (HCPCS) procedure codes. To explore billing patterns, we assessed separate insulin exposure cohorts including patients with 1) incident NDCs, 2) incident HCPCS codes, 3) incident NDCs or HCPCS codes, 4) prevalent NDCs, 5) prevalent HCPCS codes, and 6) prevalent NDCs or HCPCS codes. Incident cohorts included members with no evidence of the cohort-specific code type for insulin in the 183 days prior to their first qualifying (index) dispensing or procedure. Prevalent cohorts did not require an exposure washout period. For each cohort, all qualifying dispensings or procedures were included; cohort re-entry was allowed. However, in the incident cohorts we only assessed the incidence-defining washout criteria with respect to the first index exposure.

We built insulin treatment episodes using the outpatient dispensing data's reported days supply values. Please note that HCPCS codes are assigned a days supply value of 1 day. We considered gaps of less than 30 days between valid exposures as continuous exposure. We added an additional 30-day extension period to the end of each treatment episode and treated it as continuous exposure. We assessed members' exposure episodes in each cohort until evidence of one of the following occurred: 1) episode end, 2) death, 3) disenrollment, 4) query end date, 5) evidence of the opposite exposure-defining code type (for cohorts defined by only NDCs or only HCPCS).

Please see Appendix B for a list of generic and brand names of medical products and Appendix C for a list of procedure codes used to define the exposures in this request.

Cohort Eligibility Criteria: We required members included in the cohorts to be continuously enrolled in health plans with medical and drug coverage in the 183 days prior to their index exposure date, during which gaps in coverage of up to 45 days were allowed and treated as continuous enrollment. The following age groups were included in the cohort: 18-44, 45-64, and 65+ years.

Overview for Request: cder_mpl1r_wp178

Baseline Characteristics: We reported each member's sex, race, age, and year of exposure at the time of each member's index insulin exposure episode. We also assessed the recorded history of 37 characteristics among each insulin cohort in the 183 days prior to index. We defined 26 of the characteristics using Centers for Medicare and Medicaid Services' (CMS) Chronic Conditions Data Warehouse[1] (CCW) algorithms. These included: acquired hypothyroidism, acute myocardial infarction, Alzheimer's disease and related conditions, anemia, asthma, atrial fibrillation, benign prostatic hyperplasia, breast cancer, cataracts, chronic kidney disease, chronic obstructive pulmonary disease (COPD) and bronchiectasis, colorectal cancer, depression, diabetes, endometrial cancer, glaucoma, heart failure, hip/pelvic fracture, hyperlipidemia, hypertension, ischemic heart disease, lung cancer, osteoporosis, prostate cancer, rheumatoid arthritis/osteoarthritis, and stroke/transient ischemic attack. The other characteristics we assessed during the 183-day baseline period include: Charlson/Elixhauser combined comorbidity score[2], patients with diagnosis codes specific to type 1 diabetes mellitus only, patients with diagnosis codes specific to type 2 diabetes mellitus only, patients with diagnosis codes for type 1 or type 2 diabetes diabetes mellitus, patients with no evidence of type 1 or type 2 diabetes mellitus diagnosis codes, and NDCs reflecting use of metformin, sodium-glucose transport protein 2 (SGLT-2) inhibitors, dipeptidyl peptidase 4 (DPP-4) inhibitors, glucagon-like peptide 1 (GLP-1) receptor agonists, sulfonylureas, or thiazolidinediones. Finally, we assessed the healthcare utilization intensity of the cohorts, including mean number of ambulatory encounters, inpatient stays, emergency department encounters, other ambulatory encounters, and institutional stays, and mean number of generic drugs and unique drug classes dispensed.

Please see Appendix D for a list of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes and Appendix E for a list of generic and brand names of medical products used to define baseline characteristics in this request. The care settings in which

Please see Appendices G and H for the specifications of parameters used in this analysis for this request and an accompanying design diagram.

Limitations: Algorithms used to define exposures and baseline characteristics are imperfect; is it possible that misclassification may occur. Therefore, data should be interpreted with this limitation in mind.

Notes: Please contact the Sentinel Operations Center (info@sentinelsystem.org) for questions and to provide comments/suggestions for future enhancements to this document. For more information on Sentinel's routine querying modules, please refer to the documentation (https://dev.sentinelsystem.org/projects/SENTINEL/repos/sentinel-routine-querying-tool-documentation/browse).

[1]Centers for Medicare and Medicaid Services. (2018). "Chronic Conditions Data Warehouse." Available at: https://www.ccwdata.org/web/guest/condition-categories

[2]Gagne JJ, Glynn RJ, Avorn J, Levin R, Schneeweiss S. A combined comorbidity score predicted mortality in elderly patients better than existing scores. J Clin Epidemiol. 2011;64(7):749-759

Sentinel

Table of Contents

Sentinel

Table of Contents

Glossary of Terms for Analyses Using
Cohort Identification and Descriptive Analysis (CIDA) Module*

Amount Supplied - number of units (pills, tablets, vials) dispensed. Net amount per NDC per dispensing.

Blackout Period - number of days at the beginning of a treatment episode that events are to be ignored. If an event occurs during the blackout period, the episode is excluded.

Care Setting - type of medical encounter or facility where the exposure, event, or condition code was recorded. Possible care settings include: Inpatient Hospital Stay (IP), Non-Acute Institutional Stay (IS), Emergency Department (ED), Ambulatory Visit (AV), and Other Ambulatory Visit (OA). For laboratory results, possible care settings include: Emergency Department (E), Home (H), Inpatient (I), Outpatient (O), or Unknown or Missing (U). The Care Setting, along with the Principal Diagnosis Indicator (PDX), forms the Care Setting/PDX parameter.

- **Ambulatory Visit (AV) -** includes visits at outpatient clinics, same-day surgeries, urgent care visits, and other same-day ambulatory hospital encounters, but excludes emergency department encounters.
- **Emergency Department (ED) -** includes ED encounters that become inpatient stays (in which case inpatient stays would be a separate encounter). Excludes urgent care visits.
- **Inpatient Hospital Stay (IP) -** includes all inpatient stays, same-day hospital discharges, hospital transfers, and acute hospital care where the discharge is after the admission date.
- **Non-Acute Institutional Stay (IS) -** includes hospice, skilled nursing facility (SNF), rehab center, nursing home, residential, overnight non-hospital dialysis and other non-hospital stays.
- **Other Ambulatory Visit (OA) -** includes other non overnight AV encounters such as hospice visits, home health visits, skilled nursing facility visits, other non-hospital visits, as well as telemedicine, telephone and email consultations.

Charlson/Elixhauser Combined Comorbidity Score - calculated based on comorbidities observed during a requester-defined window around the exposure episode start date (e.g., in the 183 days prior to index).

Code Days - the minimum number of times the diagnosis must be found during the evaluation period in order to fulfill the algorithm to identify the corresponding patient characteristic.

Cohort Definition (drug/exposure) - indicates how the cohort will be defined: 01: Cohort includes only the first valid treatment episode during the query period; 02: Cohort includes all valid treatment episodes during the query period; 03: Cohort includes all valid treatment episodes during the query period until an event occurs.

Computed Start Marketing Date - represents the first observed dispensing date among all valid users within a GROUP (scenario) within each Data Partner site.

Days Supplied - number of days supplied for all dispensings in qualifying treatment episodes.

Eligible Members - number of members eligible for an incident treatment episode (defined by the drug/exposure and event washout periods) with drug and medical coverage during the query period.

Enrollment Gap - number of days allowed between two consecutive enrollment periods without breaking a “continuously enrolled” sequence.

Episodes - treatment episodes; length of episode is determined by days supplied in one dispensing or consecutive dispensings bridged by the episode gap.

Episode Gap - number of days allowed between two (or more) consecutive exposures (dispensings/procedures) to be considered the same treatment episode.

Event Deduplication - specifies how events are counted by the Modular Program (MP) algorithm: 0: Counts all occurrences of a health outcome of interest (HOI) during an exposure episode; 1: de-duplicates occurrences of the same HOI code and code type on the same day; 2: de-duplicates occurrences of the same HOI group on the same day (e.g., de-duplicates at the group level).

Exposure Episode Length - number of days after exposure initiation that is considered "exposed time."

Exposure Extension Period - number of days post treatment period in which the outcomes/events are counted for a treatment episode. Extensions are added after any episode gaps have been bridged.

Lookback Period - number of days wherein a member is required to have evidence of pre-existing condition (diagnosis/procedure/drug dispensing).

Maximum Episode Duration - truncates exposure episodes after a requester-specified number of exposed days. Applied after any gaps are bridged and extension days added to the length of the exposure episode.

Member-Years - sum of all days of enrollment with medical and drug coverage in the query period preceded by an exposure washout period all divided by 365.25.

Minimum Days Supplied - specifies a minimum number of days in length of the days supplied for the episode to be considered.

Minimum Episode Duration - specifies a minimum number of days in length of the episode for it to be considered. Applied after any gaps are bridged and extension days added to the length of the exposure episode.

Monitoring Period - used to define time periods of interest for both sequential analysis and simple cohort characterization requests.

Principal Diagnosis (PDX) - diagnosis or condition established to be chiefly responsible for admission of the patient to the hospital. 'P' = principal diagnosis, 'S' = secondary diagnosis, 'X' = unspecified diagnosis, '.' = blank. Along with the Care Setting values, forms the Caresetting/PDX parameter.

Query Period - period in which the modular program looks for exposures and outcomes of interest.

Switch Evaluation Step Value - value used to differentiate evaluation step. Each switch pattern can support up to 2 evaluation steps (0 = switch pattern evaluation start; 1 = first evaluation; 2 = second evaluation).

Switch Gap Inclusion Indicator - indicator for whether gaps in treatment episodes that are included in a switch episode will be counted as part of the switch episode duration.

Switch Pattern Cohort Inclusion Date - indicates which date to use for inclusion into the switch pattern cohort of interest as well as optionally as the index date of the treatment episode initiating the switch pattern. Valid options are the product approval date, product marketing date, other requester defined date, or computed start marketing date.

Switch Pattern Cohort Inclusion Strategy - indicates how the switch pattern cohort inclusion date will be used: 01: used only as a switch cohort entry date. First treatment episode dispensing date is used as index for computing time to first switch; 02: used as switch cohort entry date and as initial switch step index date for computing time to first switch.

Treatment Episode Truncation Indicator - indicates whether the exposure episode will be truncated at the occurrence of a requester-specified code.

Washout Period (drug/exposure) - number of days a user is required to have no evidence of prior exposure (drug dispensing/procedure) and continuous drug and medical coverage prior to an incident treatment episode.

Washout Period (event/outcome) - number of days a user is required to have no evidence of a prior event (procedure/diagnosis) and continuous drug and medical coverage prior to an incident treatment episode.

Years at Risk - number of days supplied plus any episode gaps and exposure extension periods all divided by 365.25.

*all terms may not be used in this report

Table 1a. Baseline Characteristics for Members with Prevalent Insulin Use, Defined by National Drug Codes (NDCs), in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Characteristic[1]	Number	Percent
Number of unique patients	4,113,541	100%
Demographics	**Mean**	**Standard Deviation**
Mean Age	64.9	13.0
Age (years)	**Number**	**Percent**
18-44	416,393	10.1%
45-64	1,320,935	32.1%
65+	2,376,213	57.8%
Sex		
Female	2,133,284	51.9%
Male	1,980,257	48.1%
Race[2]		
Unknown	1,063,129	25.8%
American Indian or Alaska Native	31,412	0.8%
Asian	90,381	2.2%
Black or African American	585,876	14.2%
Native Hawaiian or Other Pacific Islander	10,978	0.3%
White	2,331,765	56.7%
Hispanic Origin[2]	170,872	4.2%
Year		
2013	1,366,680	33.2%
2014	699,347	17.0%
2015	574,520	14.0%
2016	531,911	12.9%
2017	489,782	11.9%
2018	451,301	11.0%
Diabetes Type:		
Type 1 Diabetes Only	132,149	3.2%
Type 2 Diabetes Only	3,070,259	74.6%
Type 1 or Type 2 Diabetes	3,910,490	95.1%
Not Type 1 nor Type 2 Diabetes	203,051	4.9%
Recorded History of in 183 Days Prior to Index:	**Mean**	**Standard Deviation**
Prior combined comorbidity score	2.8	3.2
	Number	**Percent**
Acquired hypothyroidism	544,958	13.2%
Acute myocardial infarction	83,806	2.0%
Alzheimer's disease and related conditions	388,159	9.4%
Anemia	1,193,328	29.0%
Asthma	240,487	5.8%
Atrial fibrillation	431,931	10.5%
Benign prostatic hyperplasia	192,286	4.7%
Breast cancer	80,800	2.0%
Cataract	737,025	17.9%
Chronic kidney disease	1,548,384	37.6%

Table 1a. Baseline Characteristics for Members with Prevalent Insulin Use, Defined by National Drug Codes (NDCs), in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Recorded History of in 183 Days Prior to Index:	Number	Percent
Colorectal cancer	46,073	1.1%
Chronic obstructive pulmonary disease (COPD) and bronchiectasis	575,926	14.0%
Depression	839,962	20.4%
Diabetes	3,626,348	88.2%
Endometrial cancer	10,222	0.2%
Glaucoma	368,297	9.0%
Heart failure	818,561	19.9%
Hip/Pelvic fracture	37,387	0.9%
Hyperlipidemia	2,083,078	50.6%
Hypertension	2,725,060	66.2%
Ischemic heart disease	1,266,172	30.8%
Lung cancer	37,949	0.9%
Osteoporosis	117,408	2.9%
Prostate cancer	74,224	1.8%
Rheumatoid arthritis/osteoarthritis	613,652	14.9%
Stroke/Transient ischemic attack (TIA)	245,976	6.0%
History of Use in 183 Days Prior to Index:		
Metformin	1,878,575	45.7%
Sodium-glucose co-transporter-2 (SGLT-2) inhibitors	137,149	3.3%
Dipeptidyl peptidase-4 (DPP-4) inhibitors	261,728	6.4%
Glucagon-like peptide-1 (GLP-1) receptor agonists	613,210	14.9%
Sulfonylureas	1,304,698	31.7%
Thiazolidinediones	208,674	5.1%
Health Service Utilization Intensity:	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters (AV)	14.1	18.2
Mean number of emergency room encounters (ED)	0.5	1.3
Mean number of inpatient hospital encounters (IP)	0.5	1.0
Mean number of non-acute institutional encounters (IS)	0.3	0.9
Mean number of other ambulatory encounters (OA)	8.8	16.4
Mean number of unique drug classes	10.0	4.9
Mean number of generics	11.2	5.6

[2]In the SDD, race information is not well populated and there are substantial proportions of "unknown" race and Hispanic indicator values. Specifically, two commercial Data Partners do not provide any race or ethnicity data.

Table 1b. Baseline Characteristics for Members with Prevalent Insulin Use, Defined by Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Characteristic[1]	Number	Percent
Number of unique patients	897,179	100%
Demographics	**Mean**	**Standard Deviation**
Mean Age	66.8	13.4
Age (years)	**Number**	**Percent**
18-44	68,744	7.7%
45-64	274,906	30.6%
65+	553,529	61.7%
Sex		
Female	473,946	52.8%
Male	423,233	47.2%
Race[2]		
Unknown	169,025	18.8%
American Indian or Alaska Native	9,865	1.1%
Asian	17,722	2.0%
Black or African American	145,233	16.2%
Native Hawaiian or Other Pacific Islander	837	0.1%
White	554,497	61.8%
Hispanic Origin[2]	40,404	4.5%
Year		
2013	150,395	16.8%
2014	147,916	16.5%
2015	146,048	16.3%
2016	148,303	16.5%
2017	152,871	17.0%
2018	151,646	16.9%
Diabetes Type:		
Type 1 Diabetes Only	5,333	0.6%
Type 2 Diabetes Only	690,475	77.0%
Type 1 or Type 2 Diabetes	855,057	95.3%
Not Type 1 nor Type 2 Diabetes	42,122	4.7%
Recorded History of in 183 Days Prior to Index:	**Mean**	**Standard Deviation**
Prior combined comorbidity score	4.1	3.3
	Number	**Percent**
Acquired hypothyroidism	149,775	16.7%
Acute myocardial infarction	26,387	2.9%
Alzheimer's disease and related conditions	88,412	9.9%
Anemia	340,729	38.0%
Asthma	83,017	9.3%
Atrial fibrillation	133,821	14.9%
Benign prostatic hyperplasia	61,547	6.9%
Breast cancer	27,928	3.1%
Cataract	176,792	19.7%
Chronic kidney disease	417,568	46.5%

Table 1b. Baseline Characteristics for Members with Prevalent Insulin Use, Defined by Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Recorded History of in 183 Days Prior to Index:	Number	Percent
Colorectal cancer	14,210	1.6%
Chronic obstructive pulmonary disease (COPD) and bronchiectasis	175,974	19.6%
Depression	244,538	27.3%
Diabetes	808,158	90.1%
Endometrial cancer	4,779	0.5%
Glaucoma	92,175	10.3%
Heart failure	268,135	29.9%
Hip/Pelvic fracture	5,738	0.6%
Hyperlipidemia	550,413	61.3%
Hypertension	732,372	81.6%
Ischemic heart disease	420,043	46.8%
Lung cancer	11,687	1.3%
Osteoporosis	31,545	3.5%
Prostate cancer	23,141	2.6%
Rheumatoid arthritis/osteoarthritis	191,751	21.4%
Stroke/Transient ischemic attack (TIA)	59,887	6.7%
History of Use in 183 Days Prior to Index:		
Metformin	378,168	42.2%
Sodium-glucose co-transporter-2 (SGLT-2) inhibitors	21,852	2.4%
Dipeptidyl peptidase-4 (DPP-4) inhibitors	39,255	4.4%
Glucagon-like peptide-1 (GLP-1) receptor agonists	111,084	12.4%
Sulfonylureas	238,478	26.6%
Thiazolidinediones	33,857	3.8%
Health Service Utilization Intensity:	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters (AV)	20.6	22.8
Mean number of emergency room encounters (ED)	1.6	2.2
Mean number of inpatient hospital encounters (IP)	0.6	1.2
Mean number of non-acute institutional encounters (IS)	0.2	0.7
Mean number of other ambulatory encounters (OA)	9.1	15.6
Mean number of unique drug classes	10.8	5.5
Mean number of generics	12.0	6.3

[1]All metrics based on total number of unique patients

[2]In the SDD, race information is not well populated and there are substantial proportions of "unknown" race and Hispanic indicator values. Specifically, two commercial Data Partners do not provide any race or ethnicity data.

Table 1c. Baseline Characteristics for Members with Prevalent Insulin Use, Defined by National Drug Codes (NDCs) or Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Characteristic[1]	Number	Percent
Number of unique patients	4,424,837	100%
Demographics	**Mean**	**Standard Deviation**
Mean Age	65.2	13.0
Age (years)	**Number**	**Percent**
18-44	436,684	9.9%
45-64	1,403,117	31.7%
65+	2,585,036	58.4%
Sex		
Female	2,291,830	51.8%
Male	2,133,007	48.2%
Race[2]		
Unknown	1,129,545	25.5%
American Indian or Alaska Native	34,008	0.8%
Asian	97,852	2.2%
Black or African American	628,947	14.2%
Native Hawaiian or Other Pacific Islander	11,322	0.3%
White	2,523,163	57.0%
Hispanic Origin[2]	183,073	4.1%
Year		
2013	1,424,182	32.2%
2014	749,663	16.9%
2015	623,440	14.1%
2016	581,118	13.1%
2017	541,683	12.2%
2018	504,751	11.4%
Diabetes Type:		
Type 1 Diabetes Only	132,752	3.0%
Type 2 Diabetes Only	3,329,033	75.2%
Type 1 or Type 2 Diabetes	4,182,638	94.5%
Not Type 1 nor Type 2 Diabetes	242,199	5.5%
Recorded History of in 183 Days Prior to Index:	**Mean**	**Standard Deviation**
Prior combined comorbidity score	2.8	3.2
	Number	**Percent**
Acquired hypothyroidism	589,339	13.3%
Acute myocardial infarction	90,319	2.0%
Alzheimer's disease and related conditions	412,495	9.3%
Anemia	1,293,631	29.2%
Asthma	265,806	6.0%
Atrial fibrillation	476,320	10.8%
Benign prostatic hyperplasia	214,077	4.8%
Breast cancer	91,186	2.1%
Cataract	793,259	17.9%

Table 1c. Baseline Characteristics for Members with Prevalent Insulin Use, Defined by National Drug Codes (NDCs) or Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Recorded History of in 183 Days Prior to Index:	Number	Percent
Chronic kidney disease	1,638,977	37.0%
Colorectal cancer	51,153	1.2%
Chronic obstructive pulmonary disease (COPD) and bronchiectasis	628,616	14.2%
Depression	906,013	20.5%
Diabetes	3,864,246	87.3%
Endometrial cancer	12,101	0.3%
Glaucoma	398,928	9.0%
Heart failure	891,942	20.2%
Hip/Pelvic fracture	38,680	0.9%
Hyperlipidemia	2,255,510	51.0%
Hypertension	2,963,895	67.0%
Ischemic heart disease	1,397,198	31.6%
Lung cancer	42,342	1.0%
Osteoporosis	127,567	2.9%
Prostate cancer	83,883	1.9%
Rheumatoid arthritis/osteoarthritis	678,837	15.3%
Stroke/Transient ischemic attack (TIA)	260,382	5.9%
History of Use in 183 Days Prior to Index:		
Metformin	2,031,304	45.9%
Sodium-glucose co-transporter-2 (SGLT-2) inhibitors	141,809	3.2%
Dipeptidyl peptidase-4 (DPP-4) inhibitors	267,388	6.0%
Glucagon-like peptide-1 (GLP-1) receptor agonists	646,447	14.6%
Sulfonylureas	1,395,029	31.5%
Thiazolidinediones	221,316	5.0%
Health Service Utilization Intensity:	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters (AV)	14.3	18.4
Mean number of emergency room encounters (ED)	0.6	1.4
Mean number of inpatient hospital encounters (IP)	0.5	1.0
Mean number of non-acute institutional encounters (IS)	0.3	0.9
Mean number of other ambulatory encounters (OA)	8.5	16.1
Mean number of unique drug classes	9.9	5.0
Mean number of generics	11.1	5.6

[1]All metrics based on total number of unique patients

[2]In the SDD, race information is not well populated and there are substantial proportions of "unknown" race and Hispanic indicator values. Specifically, two commercial Data Partners do not provide any race or ethnicity data.

Table 1d. Baseline Characteristics for Members with Incident Insulin Use, Defined by National Drug Codes (NDCs), in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Characteristic[1]	Number	Percent
Number of unique patients	2,404,732	100%
Demographics	**Mean**	**Standard Deviation**
Mean Age	65.2	13.1
Age (years)	**Number**	**Percent**
18-44	245,315	10.2%
45-64	774,292	32.2%
65+	1,385,125	57.6%
Sex		
Female	1,229,346	51.1%
Male	1,175,386	48.9%
Race[2]		
Unknown	621,502	25.8%
American Indian or Alaska Native	18,690	0.8%
Asian	58,601	2.4%
Black or African American	337,681	14.0%
Native Hawaiian or Other Pacific Islander	6,930	0.3%
White	1,361,328	56.6%
Hispanic Origin[2]	101,106	4.2%
Year		
2013	477,899	19.9%
2014	430,276	17.9%
2015	396,256	16.5%
2016	385,879	16.0%
2017	367,873	15.3%
2018	346,549	14.4%
Diabetes Type:		
Type 1 Diabetes Only	40,721	1.7%
Type 2 Diabetes Only	1,935,868	80.5%
Type 1 or Type 2 Diabetes	2,276,172	94.7%
Not Type 1 nor Type 2 Diabetes	128,560	5.3%
Recorded History of in 183 Days Prior to Index:	**Mean**	**Standard Deviation**
Prior combined comorbidity score	3.1	3.4
	Number	**Percent**
Acquired hypothyroidism	327,078	13.6%
Acute myocardial infarction	57,979	2.4%
Alzheimer's disease and related conditions	258,288	10.7%
Anemia	739,175	30.7%
Asthma	153,093	6.4%
Atrial fibrillation	281,167	11.7%
Benign prostatic hyperplasia	129,807	5.4%
Breast cancer	50,401	2.1%
Cataract	407,325	16.9%
Chronic kidney disease	1,010,967	42.0%

Table 1d. Baseline Characteristics for Members with Incident Insulin Use, Defined by National Drug Codes (NDCs), in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Recorded History of in 183 Days Prior to Index:	Number	Percent
Colorectal cancer	29,891	1.2%
Chronic obstructive pulmonary disease (COPD) and bronchiectasis	377,414	15.7%
Depression	515,688	21.4%
Diabetes	2,121,337	88.2%
Endometrial cancer	6,994	0.3%
Glaucoma	200,415	8.3%
Heart failure	504,907	21.0%
Hip/Pelvic fracture	25,276	1.1%
Hyperlipidemia	1,249,565	52.0%
Hypertension	1,646,078	68.5%
Ischemic heart disease	754,677	31.4%
Lung cancer	28,222	1.2%
Osteoporosis	73,679	3.1%
Prostate cancer	48,988	2.0%
Rheumatoid arthritis/osteoarthritis	380,701	15.8%
Stroke/Transient ischemic attack (TIA)	162,176	6.7%
History of Use in 183 Days Prior to Index:		
Metformin	1,222,989	50.9%
Sodium-glucose co-transporter-2 (SGLT-2) inhibitors	97,202	4.0%
Dipeptidyl peptidase-4 (DPP-4) inhibitors	163,982	6.8%
Glucagon-like peptide-1 (GLP-1) receptor agonists	442,759	18.4%
Sulfonylureas	951,000	39.5%
Thiazolidinediones	140,470	5.8%
Health Service Utilization Intensity:	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters (AV)	14.3	18.4
Mean number of emergency room encounters (ED)	0.6	1.4
Mean number of inpatient hospital encounters (IP)	0.6	1.0
Mean number of non-acute institutional encounters (IS)	0.3	0.9
Mean number of other ambulatory encounters (OA)	9.6	17.4
Mean number of unique drug classes	10.0	5.0
Mean number of generics	11.2	5.6

[1]All metrics based on total number of unique patients

[2]In the SDD, race information is not well populated and there are substantial proportions of "unknown" race and Hispanic indicator values. Specifically, two commercial Data Partners do not provide any race or ethnicity data.

Table 1e. Baseline Characteristics for Members with Incident Insulin Use, Defined by Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Characteristic[1]	Number	Percent
Number of unique patients	888,784	100%
Demographics	**Mean**	**Standard Deviation**
Mean Age	66.9	13.3
Age (years)	**Number**	**Percent**
18-44	67,244	7.6%
45-64	271,378	30.5%
65+	550,162	61.9%
Sex		
Female	469,499	52.8%
Male	419,285	47.2%
Race[2]		
Unknown	166,960	18.8%
American Indian or Alaska Native	9,764	1.1%
Asian	17,598	2.0%
Black or African American	143,388	16.1%
Native Hawaiian or Other Pacific Islander	835	0.1%
White	550,239	61.9%
Hispanic Origin[2]	39,911	4.5%
Year		
2013	144,550	16.3%
2014	147,986	16.7%
2015	145,620	16.4%
2016	147,640	16.6%
2017	152,032	17.1%
2018	150,956	17.0%
Diabetes Type:		
Type 1 Diabetes Only	5,281	0.6%
Type 2 Diabetes Only	685,399	77.1%
Type 1 or Type 2 Diabetes	846,743	95.3%
Not Type 1 nor Type 2 Diabetes	42,041	4.7%
Recorded History of in 183 Days Prior to Index:	**Mean**	**Standard Deviation**
Prior combined comorbidity score	4.1	3.3
	Number	**Percent**
Acquired hypothyroidism	148,325	16.7%
Acute myocardial infarction	25,999	2.9%
Alzheimer's disease and related conditions	87,705	9.9%
Anemia	336,558	37.9%
Asthma	81,584	9.2%
Atrial fibrillation	132,614	14.9%
Benign prostatic hyperplasia	60,983	6.9%
Breast cancer	27,680	3.1%
Cataract	175,426	19.7%
Chronic kidney disease	412,752	46.4%

Table 1e. Baseline Characteristics for Members with Incident Insulin Use, Defined by Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Recorded History of in 183 Days Prior to Index:	Number	Percent
Colorectal cancer	14,053	1.6%
Chronic obstructive pulmonary disease (COPD) and bronchiectasis	173,707	19.5%
Depression	241,082	27.1%
Diabetes	799,805	90.0%
Endometrial cancer	4,738	0.5%
Glaucoma	91,486	10.3%
Heart failure	264,874	29.8%
Hip/Pelvic fracture	5,693	0.6%
Hyperlipidemia	544,493	61.3%
Hypertension	724,774	81.5%
Ischemic heart disease	415,641	46.8%
Lung cancer	11,586	1.3%
Osteoporosis	31,267	3.5%
Prostate cancer	22,972	2.6%
Rheumatoid arthritis/osteoarthritis	189,837	21.4%
Stroke/Transient ischemic attack (TIA)	58,972	6.6%
History of Use in 183 Days Prior to Index:		
Metformin	375,317	42.2%
Sodium-glucose co-transporter-2 (SGLT-2) inhibitors	21,751	2.4%
Dipeptidyl peptidase-4 (DPP-4) inhibitors	39,023	4.4%
Glucagon-like peptide-1 (GLP-1) receptor agonists	110,254	12.4%
Sulfonylureas	236,525	26.6%
Thiazolidinediones	33,596	3.8%
Health Service Utilization Intensity:	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters (AV)	20.5	22.7
Mean number of emergency room encounters (ED)	1.5	2.1
Mean number of inpatient hospital encounters (IP)	0.6	1.2
Mean number of non-acute institutional encounters (IS)	0.2	0.7
Mean number of other ambulatory encounters (OA)	9.0	15.5
Mean number of unique drug classes	10.7	5.5
Mean number of generics	12.0	6.3

[1]All metrics based on total number of unique patients

[2]In the SDD, race information is not well populated and there are substantial proportions of "unknown" race and Hispanic indicator values. Specifically, two commercial Data Partners do not provide any race or ethnicity data.

Table 1f. Baseline Characteristics for Members with Incident Insulin Use, Defined by National Drug Codes (NDCs) or Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Characteristic[1]	Number	Percent
Number of unique patients	2,707,263	100%
Demographics	**Mean**	**Standard Deviation**
Mean Age	65.6	13.1
Age (years)	**Number**	**Percent**
18-44	263,994	9.8%
45-64	852,647	31.5%
65+	1,590,622	58.8%
Sex		
Female	1,383,179	51.1%
Male	1,324,084	48.9%
Race[2]		
Unknown	685,508	25.3%
American Indian or Alaska Native	21,197	0.8%
Asian	65,935	2.4%
Black or African American	378,727	14.0%
Native Hawaiian or Other Pacific Islander	7,270	0.3%
White	1,548,626	57.2%
Hispanic Origin[2]	112,804	4.2%
Year		
2013	528,602	19.5%
2014	479,993	17.7%
2015	444,538	16.4%
2016	434,656	16.1%
2017	419,524	15.5%
2018	399,950	14.8%
Diabetes Type:		
Type 1 Diabetes Only	41,265	1.5%
Type 2 Diabetes Only	2,189,390	80.9%
Type 1 or Type 2 Diabetes	2,539,557	93.8%
Not Type 1 nor Type 2 Diabetes	167,706	6.2%
Recorded History of in 183 Days Prior to Index:	**Mean**	**Standard Deviation**
Prior combined comorbidity score	3.1	3.3
	Number	**Percent**
Acquired hypothyroidism	369,852	13.7%
Acute myocardial infarction	64,063	2.4%
Alzheimer's disease and related conditions	281,569	10.4%
Anemia	834,993	30.8%
Asthma	176,887	6.5%
Atrial fibrillation	324,302	12.0%
Benign prostatic hyperplasia	151,000	5.6%
Breast cancer	60,553	2.2%
Cataract	462,225	17.1%
Chronic kidney disease	1,096,378	40.5%

Table 1f. Baseline Characteristics for Members with Incident Insulin Use, Defined by National Drug Codes (NDCs) or Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018

Recorded History of in 183 Days Prior to Index:	Number	Percent
Colorectal cancer	34,803	1.3%
Chronic obstructive pulmonary disease (COPD) and bronchiectasis	427,633	15.8%
Depression	578,140	21.4%
Diabetes	2,350,084	86.8%
Endometrial cancer	8,819	0.3%
Glaucoma	230,424	8.5%
Heart failure	574,724	21.2%
Hip/Pelvic fracture	26,405	1.0%
Hyperlipidemia	1,415,734	52.3%
Hypertension	1,876,795	69.3%
Ischemic heart disease	881,226	32.6%
Lung cancer	32,506	1.2%
Osteoporosis	83,548	3.1%
Prostate cancer	58,459	2.2%
Rheumatoid arthritis/osteoarthritis	443,985	16.4%
Stroke/Transient ischemic attack (TIA)	175,297	6.5%
History of Use in 183 Days Prior to Index:		
Metformin	1,372,349	50.7%
Sodium-glucose co-transporter-2 (SGLT-2) inhibitors	101,769	3.8%
Dipeptidyl peptidase-4 (DPP-4) inhibitors	169,210	6.3%
Glucagon-like peptide-1 (GLP-1) receptor agonists	474,943	17.5%
Sulfonylureas	1,039,064	38.4%
Thiazolidinediones	152,819	5.6%
Health Service Utilization Intensity:	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters (AV)	14.7	18.6
Mean number of emergency room encounters (ED)	0.7	1.5
Mean number of inpatient hospital encounters (IP)	0.5	1.0
Mean number of non-acute institutional encounters (IS)	0.3	0.9
Mean number of other ambulatory encounters (OA)	9.1	16.8
Mean number of unique drug classes	9.8	5.0
Mean number of generics	10.9	5.6

[1]All metrics based on total number of unique patients

[2]In the SDD, race information is not well populated and there are substantial proportions of "unknown" race and Hispanic indicator values. Specifically, two commercial Data Partners do not provide any race or ethnicity data.

Table 2a. Distribution of Cumulative Insulin Exposure Duration, for All Insulin Treatment Episodes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Exposure Episode Duration (days)		Index-Defining Billing Code Type					
		Prevalent Insulin Billings			Incident Insulin Billings		
		NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]	NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]
Total Patients	Number	4,113,541	897,179	4,424,837	2,404,732	888,784	2,707,263
	Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1-30	Number	136,024	255,277	138,373	100,002	253,289	104,417
	Percent	3.3%	28.5%	3.1%	4.2%	28.5%	3.9%
31-60	Number	337,712	528,749	579,281	280,606	525,426	525,332
	Percent	8.2%	58.9%	13.1%	11.7%	59.1%	19.4%
61-90	Number	175,835	76,596	198,672	130,212	75,371	154,377
	Percent	4.3%	8.5%	4.5%	5.4%	8.5%	5.7%
91-183	Number	555,545	31,610	559,899	400,649	30,428	408,246
	Percent	13.5%	3.5%	12.7%	16.7%	3.4%	15.1%
184-365	Number	667,873	4,235	659,438	432,752	3,762	430,256
	Percent	16.2%	0.5%	14.9%	18.0%	0.4%	15.9%
366-731 (1-2 Years)	Number	854,305	630	844,264	488,731	460	486,890
	Percent	20.8%	0.1%	19.1%	20.3%	0.1%	18.0%
732-1096 (2-3 Years)	Number	560,204	59	561,381	279,121	*****	283,456
	Percent	13.6%	0.0%	12.7%	11.6%	0.0%	10.5%
1097-1461 (3-4 Years)	Number	397,818	*****	408,975	165,831	*****	173,933
	Percent	9.7%	0.0%	9.2%	6.9%	0.0%	6.4%
1462-1826 (4-5 Years)	Number	280,860	*****	303,865	91,048	*****	99,517
	Percent	6.8%	0.0%	6.9%	3.8%	0.0%	3.7%
1827-2192 (5-6 Years)	Number	147,365	0	170,689	35,780	0	40,839
	Percent	3.6%	0.0%	3.9%	1.5%	0.0%	1.5%

*****Data are not presented in these cells due to a small sample size or to assure a small cell cannot be recalculated through the cells presented.

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 2b. Descriptive Statistics of Cumulative Insulin Exposure Duration, for All Insulin Treatment Episodes, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Index-Defining Billing Code Type	Total Patients	Mean (days)	Standard Deviation (days)	Minimum (days)	Q1 (days)	Median (days)	Q3 (days)	Maximum (days)
Prevalent Insulin Billings								
NDCs[1]	4,113,541	609.00	545.84	1	149	432	950	2,191
HCPCS[2]	897,179	34.27	30.69	1	25	31	32	1,754
NDCs[1] or HCPCS[2]	4,424,837	589.18	560.17	1	120	393	937	2,191
Incident Insulin Billings								
NDCs[1]	2,404,732	471.71	467.19	1	113	298	703	2,191
HCPCS[2]	888,784	33.90	28.63	1	25	31	31	1,619
NDCs[1] or HCPCS[2]	2,707,263	436.22	472.66	1	66	240	657	2,191

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 3a. Distribution of First Insulin Exposure Episode Duration in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Exposure Episode Duration (days)		Index-Defining Billing Code Type					
		Prevalent Insulin Billings			Incident Insulin Billings		
		NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]	NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]
Total Episodes	Number	4,113,541	897,179	4,424,837	2,404,732	888,784	2,707,263
	Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1-30	Number	161,391	311,202	145,530	115,972	307,848	108,082
	Percent	3.9%	34.7%	3.3%	4.8%	34.6%	4.0%
31-60	Number	1,072,489	583,679	1,400,269	700,106	578,788	1,029,054
	Percent	26.1%	65.1%	31.6%	29.1%	65.1%	38.0%
61-90	Number	397,729	1,771	393,436	246,621	1,663	243,492
	Percent	9.7%	0.2%	8.9%	10.3%	0.2%	9.0%
91-183	Number	1,105,194	385	1,090,878	647,347	356	632,698
	Percent	26.9%	0.0%	24.7%	26.9%	0.0%	23.4%
184-365	Number	669,825	115	665,148	346,739	102	340,329
	Percent	16.3%	0.0%	15.0%	14.4%	0.0%	12.6%
366-731 (1-2 Years)	Number	416,569	*****	420,491	208,514	*****	207,618
	Percent	10.1%	0.0%	9.5%	8.7%	0.0%	7.7%
732-1096 (2-3 Years)	Number	153,602	*****	159,213	76,289	*****	77,972
	Percent	3.7%	0.0%	3.6%	3.2%	0.0%	2.9%
1097+ (3+ Years)	Number	136,742	0	149,872	63,144	0	68,018
	Percent	3.3%	0.0%	3.4%	2.6%	0.0%	2.5%

*****Data are not presented in these cells due to a small sample size or to assure a small cell cannot be recalculated through the cells presented.

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 3b. Descriptive Statistics of First Insulin Exposure Episode Duration in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Index-Defining Billing Code Type	Total Episodes	Mean (days)	Standard Deviation (days)	Minimum (days)	Q1 (days)	Median (days)	Q3 (days)	Maximum (days)
Prevalent Insulin Billings								
NDCs[1]	4,113,541	233.84	313.11	1	60	120	251	2,191
HCPCS[2]	897,179	25.06	11.70	1	19	31	31	1,034
NDCs[1] or HCPCS[2]	4,424,837	225.24	317.05	1	60	114	237	2,191
Incident Insulin Billings								
NDCs[1]	2,404,732	207.41	285.83	1	60	110	212	2,191
HCPCS[2]	888,784	25.06	11.64	1	19	31	31	1,034
NDCs[1] or HCPCS[2]	2,707,263	189.75	282.62	1	58	90	191	2,191

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 4a. Distribution of Second and Subsequent Insulin Exposure Episode Durations in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Exposure Episode Duration (days)		Index-Defining Billing Code Type					
		Prevalent Insulin Billings			Incident Insulin Billings		
		NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]	NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]
Total Episodes	Number	8,809,052	343,709	9,040,271	3,946,140	328,880	4,113,812
	Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1-30	Number	311,912	154,051	270,222	160,041	147,994	143,720
	Percent	3.5%	44.8%	3.0%	4.1%	45.0%	3.5%
31-60	Number	2,642,132	186,567	2,785,294	1,251,332	178,314	1,366,014
	Percent	30.0%	54.3%	30.8%	31.7%	54.2%	33.2%
61-90	Number	1,011,826	2,393	1,021,092	466,097	2,026	473,466
	Percent	11.5%	0.7%	11.3%	11.8%	0.6%	11.5%
91-183	Number	2,568,967	617	2,598,464	1,153,667	484	1,172,544
	Percent	29.2%	0.2%	28.7%	29.2%	0.1%	28.5%
184-365	Number	1,327,543	*****	1,358,610	551,266	*****	568,019
	Percent	15.1%	0.0%	15.0%	14.0%	0.0%	13.8%
366-731 (1-2 Years)	Number	644,139	*****	674,289	255,490	*****	270,076
	Percent	7.3%	0.0%	7.5%	6.5%	0.0%	6.6%
732-1096 (2-3 Years)	Number	192,279	0	207,901	71,911	0	78,686
	Percent	2.2%	0.0%	2.3%	1.8%	0.0%	1.9%
1097+ (3+ Years)	Number	110,254	0	124,399	36,336	0	41,287
	Percent	1.3%	0.0%	1.4%	0.9%	0.0%	1.0%

*****Data are not presented in these cells due to a small sample size or to assure a small cell cannot be recalculated through the cells presented.

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 4b. Descriptive Statistics of Second and Subsequent Insulin Exposure Episode Durations in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Index-Defining Billing Code Type	Total Episodes	Mean (days)	Standard Deviation (days)	Minimum (days)	Q1 (days)	Median (days)	Q3 (days)	Maximum (days)
Prevalent Insulin Billings								
NDCs[1]	8,809,052	175.19	219.02	1	60	105	191	2,147
HCPCS[2]	343,709	24.03	13.47	1	14	31	31	450
NDCs[1] or HCPCS[2]	9,040,271	178.14	225.73	1	60	105	194	2,147
Incident Insulin Billings								
NDCs[1]	3,946,140	161.06	198.53	1	60	98	171	2,128
HCPCS[2]	328,880	23.90	13.16	1	13	31	31	450
NDCs[1] or HCPCS[2]	4,113,812	162.20	203.96	1	60	96	171	2,128

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 5a. Distribution of All Insulin Episode Durations in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Exposure Episode Duration (days)		Index-Defining Billing Code Type					
		Prevalent Insulin Billings			Incident Insulin Billings		
		NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]	NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]
Total Episodes	Number	12,922,593	1,240,888	13,465,108	6,350,872	1,217,664	6,821,075
	Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1-30	Number	473,303	465,253	415,752	276,013	455,842	251,802
	Percent	3.7%	37.5%	3.1%	4.3%	37.4%	3.7%
31-60	Number	3,714,621	770,246	4,185,563	1,951,438	757,102	2,395,068
	Percent	28.7%	62.1%	31.1%	30.7%	62.2%	35.1%
61-90	Number	1,409,555	4,164	1,414,528	712,718	3,689	716,958
	Percent	10.9%	0.3%	10.5%	11.2%	0.3%	10.5%
91-183	Number	3,674,161	1,002	3,689,342	1,801,014	840	1,805,242
	Percent	28.4%	0.1%	27.4%	28.4%	0.1%	26.5%
184-365	Number	1,997,368	192	2,023,758	898,005	161	908,348
	Percent	15.5%	0.0%	15.0%	14.1%	0.0%	13.3%
366-731 (1-2 Years)	Number	1,060,708	*****	1,094,780	464,004	*****	477,694
	Percent	8.2%	0.0%	8.1%	7.3%	0.0%	7.0%
732-1096 (2-3 Years)	Number	345,881	*****	367,114	148,200	*****	156,658
	Percent	2.7%	0.0%	2.7%	2.3%	0.0%	2.3%
1097+ (3+ Years)	Number	246,996	0	274,271	99,480	0	109,305
	Percent	1.9%	0.0%	2.0%	1.6%	0.0%	1.6%

*****Data are not presented in these cells due to a small sample size or to assure a small cell cannot be recalculated through the cells presented.

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 5b. Descriptive Statistics of All Insulin Exposure Episode Durations in the Sentinel Distributed Database between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Index-Defining Billing Code Type	Total Episodes	Mean (days)	Standard Deviation (days)	Minimum (days)	Q1 (days)	Median (days)	Q3 (days)	Maximum (days)
Prevalent Insulin Billings								
NDCs[1]	12,922,593	193.86	254.27	1	60	112	210	2,191
HCPCS[2]	1,240,888	24.78	12.22	1	17	31	31	1,034
NDCs[1] or HCPCS[2]	13,465,108	193.61	260.25	1	60	108	210	2,191
Incident Insulin Billings								
NDCs[1]	6,350,872	178.61	236.50	1	60	104	187	2,191
HCPCS[2]	1,217,664	24.74	12.08	1	17	31	31	1,034
NDCs[1] or HCPCS[2]	6,821,075	173.14	238.69	1	60	93	179	2,191

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 6a. Distribution of Days Supplied per Dispensing for Insulin Treatment Episodes in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Days Supplied per Dispensing (days)		Index-Defining Billing Code Type					
		Prevalent Insulin Billings			Incident Insulin Billings		
		NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]	NDCs[1]	HCPCS[2]	NDCs[1] or HCPCS[2]
Total Dispensings	Number	64,039,914	1,495,193	67,790,140	28,020,612	1,461,688	29,752,489
	Percent	100.0	100.0	100.0	100.0	100.0	100.0
1	Number	228,665	1,495,193	1,543,452	109,432	1,461,688	1,017,026
	Percent	0.4	100.0	2.3	0.4	100.0	3.4
2-30	Number	42,781,180	0	44,346,133	18,527,482	0	19,029,652
	Percent	66.8	0.0	65.4	66.1	0.0	64.0
31-60	Number	8,938,861	0	9,362,458	3,946,749	0	4,100,252
	Percent	14.0	0.0	13.8	14.1	0.0	13.8
61-90	Number	11,376,162	0	11,798,867	5,054,284	0	5,211,091
	Percent	17.8	0.0	17.4	18.0	0.0	17.5
91+	Number	715,046	0	739,230	382,665	0	394,468
	Percent	1.1	0.0	1.1	1.4	0.0	1.3

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 6b. Descriptive Statistics of Days Supplied per Dispensing for Insulin Treatment Episodes in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Index-Defining Billing Code Type	Total Dispensings	Mean (days)	Standard Deviation (days)	Minimum (days)	Q1 (days)	Median (days)	Q3 (days)	Maximum (days)
Prevalent Insulin Billings								
NDCs[1]	64,039,914	38.75	25.71	1	25	30	45	1,059
HCPCS[2]	1,495,193	1.00	0.00	1	1	1	1	1
NDCs[1] or HCPCS[2]	67,790,140	38.05	25.96	1	25	30	44	1,059
Incident Insulin Billings								
NDCs[1]	28,020,612	39.21	26.19	1	25	30	50	1,059
HCPCS[2]	1,461,688	1.00	0.00	1	1	1	1	1
NDCs[1] or HCPCS[2]	29,752,489	38.13	26.60	1	25	30	45	1,059

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 7a. Descriptive Statistics of the Length of the First Gap between Insulin Treatment Episodes in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Index-Defining Billing Code Type	Total Gaps	Mean (days)	Standard Deviation (days)	Minimum (days)	Q1 (days)	Median (days)	Q3 (days)	Maximum (days)
Prevalent Insulin Billings								
NDCs[1]	2,572,881	96.64	185.26	1	12	35	92	2,130
HCPCS[2]	197,069	381.11	387.22	1	91	245	546	2,162
NDCs[1] or HCPCS[2]	2,655,492	101.17	197.77	1	12	35	93	2,152
Incident Insulin Billings								
NDCs[1]	1,327,817	123.64	207.67	1	17	49	132	2,119
HCPCS[2]	192,635	383.66	387.29	1	93	249	550	2,162
NDCs[1] or HCPCS[2]	1,400,913	136.77	231.40	1	17	51	143	2,134

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 7b. Descriptive Statistics of the Length of Second and Subsequent gaps between Insulin Treatment Episodes, in Days, in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Index-Defining Billing Code Type	Total Gaps	Mean (days)	Standard Deviation (days)	Minimum (days)	Q1 (days)	Median (days)	Q3 (days)	Maximum (days)
Prevalent Insulin Billings								
NDCs[1]	6,236,171	70.33	122.79	1	12	32	75	2,005
HCPCS[2]	146,640	226.11	260.72	1	54	130	299	2,047
NDCs[1] or HCPCS[2]	6,384,779	68.31	120.76	1	12	31	73	2,070
Incident Insulin Billings								
NDCs[1]	2,618,323	81.38	131.31	1	14	38	91	1,993
HCPCS[2]	136,245	231.10	261.78	1	56	136	307	2,047
NDCs[1] or HCPCS[2]	2,712,899	81.03	132.94	1	14	37	90	2,070

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 7c. Descriptive Statistics of the Length of All Gaps between Insulin Treatment Episodes in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type

Index-Defining Billing Code Type	Total Gaps	Mean (days)	Standard Deviation (days)	Minimum (days)	Q1 (days)	Median (days)	Q3 (days)	Maximum (days)
Prevalent Insulin Billings								
NDCs[1]	8,809,052	78.02	144.37	1	12	33	79	2,130
HCPCS[2]	343,709	314.98	347.63	1	70	185	434	2,162
NDCs[1] or HCPCS[2]	9,040,271	77.97	148.36	1	12	32	78	2,152
Incident Insulin Billings								
NDCs[1]	3,946,140	95.60	162.33	1	15	41	102	2,119
HCPCS[2]	328,880	320.46	349.13	1	73	192	443	2,162
NDCs[1] or HCPCS[2]	4,113,812	100.01	174.89	1	15	41	104	2,134

[1]"NDCs" refers to National Drugs Codes

[2]"HCPCS" refers to Health Care Common Procedure Coding System

Table 8a. Counts of Reason for Censoring for All Insulin Episodes among Members in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type[1]

Index-Defining Billing Code Type	Total		Disenrollment		Evidence of Death		Data Partner/Query End Date		Episode End		Insulin Code of Other Type (NDC vs HCPCS)	
Prevalent Insulin Billings	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
NDCs[2]	12,922,593	100.0%	909,143	7.0%	487,014	3.8%	1,385,262	10.7%	9,869,857	76.4%	367,658	2.8%
HCPCS[3]	1,240,888	100.0%	12,598	1.0%	21,675	1.7%	15,240	1.2%	766,595	61.8%	434,242	35.0%
NDCs[2] or HCPCS[3]	13,465,108	100.0%	945,085	7.0%	527,393	3.9%	1,460,608	10.8%	10,631,204	79.0%	-	-
Incident Insulin Billings												
NDCs[2]	6,350,872	100.0%	427,721	6.7%	249,045	3.9%	776,944	12.2%	4,776,077	75.2%	172,986	2.7%
HCPCS[3]	1,217,664	100.0%	12,245	1.0%	21,474	1.8%	15,070	1.2%	753,386	61.9%	424,782	34.9%
NDCs[2] or HCPCS[3]	6,821,075	100.0%	445,768	6.5%	271,698	4.0%	815,670	12.0%	5,341,800	78.3%	-	-

[1]Censoring criteria categories are not mutually exclusive; an episode may be censored for multiple reasons on the same day.

[2]"NDCs" refers to National Drugs Codes

[3]"HCPCS" refers to Health Care Common Procedure Coding System

Table 8b. Counts of Reason for Censoring for Each Members' First Insulin Episode among Members in the Sentinel Distributed Database (SDD) between January 1, 2013 and December 31, 2018, by Index-Defining Billing Code Type[1]

Index-Defining Billing Code Type	Total		Disenrollment		Evidence of Death		Data Partner/Query End Date		Episode End		Insulin Code of Other Type (NDC vs HCPCS)	
Prevalent Insulin Billings	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
NDCs[2]	4,113,541	100.0	369,979	9.0	201,947	4.9	415,724	10.1	3,028,160	73.6	132,406	3.2
HCPCS[3]	897,179	100.0	9,353	1.0	17,040	1.9	10,307	1.1	581,665	64.8	285,342	31.8
NDCs[2] or HCPCS[3]	4,424,837	100.0	382,287	8.6	217,795	4.9	434,696	9.8	3,425,884	77.4	-	-
Incident Insulin Billings												
NDCs[2]	2,404,732	100.0	195,651	8.1	125,869	5.2	275,272	11.4	1,754,759	73.0	74,821	3.1
HCPCS[3]	888,784	100.0	9,219	1.0	16,955	1.9	10,246	1.2	576,794	64.9	282,028	31.7
NDCs[2] or HCPCS[3]	2,707,263	100.0	201,827	7.5	136,102	5.0	283,904	10.5	2,107,914	77.9	-	-

[1]Censoring criteria categories are not mutually exclusive; an episode may be censored for multiple reasons on the same day.

[2]"NDCs" refers to National Drugs Codes

[3]"HCPCS" refers to Health Care Common Procedure Coding System

Appendix A. Dates of Available Data for Each Data Partner (DP) as of Request Distribution Date (March 17, 2020)

DP ID	Start Date[1]	End Date[1]
DP01	01/01/2008	12/31/2018
DP02	01/01/2012	06/30/2018
DP03	01/01/2010	12/31/2018
DP04	01/01/2006	12/31/2018
DP05	01/01/2000	12/31/2018
DP06	01/01/2000	12/31/2018
DP07	01/01/2000	04/30/2018
DP08	06/01/2007	12/31/2018
DP09	01/01/2000	12/31/2018
DP10	01/01/2000	12/31/2018
DP11	01/01/2005	07/31/2018
DP12	01/01/2000	12/31/2018
DP13	01/01/2000	12/31/2018
DP14	01/01/2004	12/31/2018
DP15	01/01/2008	12/31/2018
DP16	01/01/2000	12/31/2017

[1]The start and end dates are based on the minimum and maximum dates within each DP. The month with the maximum date must have at least 80% of the number of records in the previous month.

Appendix B. List of Generic and Brand Names of Medical Products Used to Define the Exposure of Interest in this Request

Generic Name	Brand Name
Insulin aspart	Novolog PenFill U-100 Insulin
Insulin aspart	Novolog Flexpen U-100 Insulin
Insulin aspart	Novolog U-100 Insulin aspart
Insulin aspart (niacinamide)	Fiasp U-100 Insulin
Insulin aspart (niacinamide)	Fiasp FlexTouch U-100 Insulin
Insulin aspart (niacinamide)	Fiasp Penfill U-100 Insulin
Insulin aspart protamine human/insulin aspart	Novolog Mix 70-30 U-100 Insuln
Insulin aspart protamine human/insulin aspart	Novolog Mix 70-30FlexPen U-100
Insulin degludec	Tresiba FlexTouch U-200
Insulin degludec	Tresiba FlexTouch U-100
Insulin degludec	Tresiba U-100 Insulin
Insulin degludec/liraglutide	Xultophy 100/3.6
Insulin detemir	Levemir U-100 Insulin
Insulin detemir	Levemir FlexTouch U-100 Insuln
Insulin detemir	Levemir Flexpen
Insulin glargine,human recombinant analog	Basaglar KwikPen U-100 Insulin
Insulin glargine,human recombinant analog	Toujeo SoloStar U-300 Insulin
Insulin glargine,human recombinant analog	Toujeo Max U-300 SoloStar
Insulin glargine,human recombinant analog	Lantus Solostar U-100 Insulin
Insulin glargine,human recombinant analog	Lantus U-100 Insulin
Insulin glargine,human recombinant analog/lixisenatide	Soliqua 100/33
Insulin glulisine	Apidra U-100 Insulin
Insulin glulisine	Apidra SoloStar U-100 Insulin
Insulin lispro	Humalog U-100 Insulin
Insulin lispro	Humalog KwikPen Insulin
Insulin lispro	Humalog Junior KwikPen U-100
Insulin lispro	Admelog U-100 Insulin lispro
Insulin lispro	Admelog SoloStar U-100 Insulin
Insulin lispro	insulin lispro
Insulin lispro protamine and insulin lispro	Humalog Mix 75-25(U-100)Insuln
Insulin lispro protamine and insulin lispro	Humalog Mix 50-50 Insuln U-100
Insulin lispro protamine and insulin lispro	Humalog Mix 75-25 KwikPen
Insulin lispro protamine and insulin lispro	Humalog Mix 50-50 KwikPen
Insulin NPH human isophane	Humulin N NPH U-100 Insulin
Insulin NPH human isophane	Humulin N Pen
Insulin NPH human isophane	Humulin N NPH Insulin KwikPen
Insulin NPH human isophane	Novolin N NPH U-100 Insulin
Insulin NPH human isophane/insulin regular, human	Humulin 70/30 U-100 Insulin
Insulin NPH human isophane/insulin regular, human	Humulin 70/30 Insulin Pen
Insulin NPH human isophane/insulin regular, human	Humulin 70/30 U-100 KwikPen
Insulin NPH human isophane/insulin regular, human	Novolin 70/30 U-100 Insulin
Insulin NPH human isophane/insulin regular, human	Novolin 70-30 FlexPen U-100
Insulin regular, human	Humulin R Regular U-100 Insuln
Insulin regular, human	Humulin R U-500 (Conc) Insulin

Appendix B. List of Generic and Brand Names of Medical Products Used to Define the Exposure of Interest in this Request

Generic Name	Brand Name
Insulin regular, human	Humulin R U-500 (Conc) Kwikpen
Insulin regular, human	Afrezza
Insulin regular, human	Novolin R Regular U-100 Insuln
Insulin regular, human in 0.9 % sodium chloride	Myxredlin

Appendix C. List of Healthcare Common Procedure Coding System (HCPCS) Procedure Codes Used to Define the Exposure of Interest in this Request

Code	Description	Code Type	Code Category
J1815	Injection, insulin, per 5 units	HCPCS	Procedure
J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units	HCPCS	Procedure
S5552	Insulin, intermediate acting (NPH or LENTE); 5 units	HCPCS	Procedure
S5553	Insulin, long acting; 5 units	HCPCS	Procedure
S5561	Insulin delivery device, reusable pen; 3 ml size	HCPCS	Procedure
S5551	Insulin, most rapid onset (Lispro or Aspart); 5 units	HCPCS	Procedure
S5550	Insulin, rapid onset, 5 units	HCPCS	Procedure
S5571	Insulin delivery device, disposable pen (including insulin); 3 ml size	HCPCS	Procedure
S5560	Insulin delivery device, reusable pen; 1.5 ml size	HCPCS	Procedure
J1820	Injection, insulin, up to 100 units	HCPCS	Procedure
S5565	Insulin cartridge for use in insulin delivery device other than pump; 150 units	HCPCS	Procedure
S5570	Insulin delivery device, disposable pen (including insulin); 1.5 ml size	HCPCS	Procedure
S5566	Insulin cartridge for use in insulin delivery device other than pump; 300 units	HCPCS	Procedure
K0548	Injection, insulin lispro, up to 50 units	HCPCS	Procedure

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
	Type 1 Diabetes Mellitus		
250.01	Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.03	Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.21	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.23	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.11	Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.13	Diabetes with ketoacidosis, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.61	Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.63	Diabetes with neurological manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.51	Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.53	Diabetes with ophthalmic manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.31	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.33	Diabetes with other coma, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.81	Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.83	Diabetes with other specified manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.71	Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.73	Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.41	Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.43	Diabetes with renal manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.91	Diabetes with unspecified complication, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.93	Diabetes with unspecified complication, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
E10.3299	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.3319	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.3499	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.37	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment	ICD-10-CM	Diagnosis
E10.37X9	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E10.3219	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3291	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3292	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3399	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.3393	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3392	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.354	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment	ICD-10-CM	Diagnosis
E10.3549	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E10.3519	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.353	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula	ICD-10-CM	Diagnosis
E10.352	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula	ICD-10-CM	Diagnosis
E10.3529	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E10.3539	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E10.3599	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.355	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E10.3419	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3493	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E10.35	Type 1 diabetes mellitus with proliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E10	Type 1 diabetes mellitus	ICD-10-CM	Diagnosis
E10.37X3	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment,	ICD-10-CM	Diagnosis
E10.37X1	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment,	ICD-10-CM	Diagnosis
E10.37X2	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left	ICD-10-CM	Diagnosis
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E10.3559	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis
E10.5	Type 1 diabetes mellitus with circulatory complications	ICD-10-CM	Diagnosis
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy	ICD-10-CM	Diagnosis
E10.61	Type 1 diabetes mellitus with diabetic arthropathy	ICD-10-CM	Diagnosis
E10.36	Type 1 diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E10.620	Type 1 diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E10.21	Type 1 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E10.641	Type 1 diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E10.2	Type 1 diabetes mellitus with kidney complications	ICD-10-CM	Diagnosis
E10.4	Type 1 diabetes mellitus with neurological complications	ICD-10-CM	Diagnosis
E10.3	Type 1 diabetes mellitus with ophthalmic complications	ICD-10-CM	Diagnosis
E10.59	Type 1 diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis
E10.618	Type 1 diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E10.638	Type 1 diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E10.628	Type 1 diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E10.69	Type 1 diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E10.6	Type 1 diabetes mellitus with other specified complications	ICD-10-CM	Diagnosis
E10.630	Type 1 diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E10.31	Type 1 diabetes mellitus with unspecified diabetic retinopathy	ICD-10-CM	Diagnosis
E10.8	Type 1 diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E10.621	Type 1 diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E10.65	Type 1 diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E10.64	Type 1 diabetes mellitus with hypoglycemia	ICD-10-CM	Diagnosis
E10.1	Type 1 diabetes mellitus with ketoacidosis	ICD-10-CM	Diagnosis
E10.63	Type 1 diabetes mellitus with oral complications	ICD-10-CM	Diagnosis
E10.622	Type 1 diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E10.62	Type 1 diabetes mellitus with skin complications	ICD-10-CM	Diagnosis
E10.9	Type 1 diabetes mellitus without complications	ICD-10-CM	Diagnosis
E10.329	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E10.321	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.32	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E10.339	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.33	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication	ICD-10-CM	Diagnosis
E10.351	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.349	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.341	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.34	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
	Type 2 Diabetes Mellitus		
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.02	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.20	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
250.22	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.10	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.12	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.60	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.62	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.50	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as	ICD-9-CM	Diagnosis
250.52	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.30	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.32	Diabetes with other coma, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.80	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.82	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.70	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.72	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.40	Diabetes with renal manifestations, type II or unspecified type, not stated as	ICD-9-CM	Diagnosis
250.42	Diabetes with renal manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.90	Diabetes with unspecified complication, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.92	Diabetes with unspecified complication, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
E11.3539	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E11.37X9	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E11.37	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment	ICD-10-CM	Diagnosis
E11.3219	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.354	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment	ICD-10-CM	Diagnosis
E11.3549	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E11.353	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula	ICD-10-CM	Diagnosis
E11.352	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula	ICD-10-CM	Diagnosis
E11.3529	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E11.355	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma	ICD-10-CM	Diagnosis
E11	Type 2 diabetes mellitus	ICD-10-CM	Diagnosis
E11.37X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	ICD-10-CM	Diagnosis
E11.37X1	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	ICD-10-CM	Diagnosis
E11.37X2	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye	ICD-10-CM	Diagnosis
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3291	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E11.3299	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.3319	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3393	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3392	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E11.3399	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis
E11.3519	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E11.3599	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E11.3559	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis
E11.3419	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3493	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3491	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3492	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E11.3499	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.5	Type 2 diabetes mellitus with circulatory complications	ICD-10-CM	Diagnosis
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy	ICD-10-CM	Diagnosis
E11.61	Type 2 diabetes mellitus with diabetic arthropathy	ICD-10-CM	Diagnosis
E11.620	Type 2 diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E11.21	Type 2 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E11.641	Type 2 diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E11.10	Type 2 diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E11.2	Type 2 diabetes mellitus with kidney complications	ICD-10-CM	Diagnosis
E11.4	Type 2 diabetes mellitus with neurological complications	ICD-10-CM	Diagnosis
E11.3	Type 2 diabetes mellitus with ophthalmic complications	ICD-10-CM	Diagnosis
E11.59	Type 2 diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication	ICD-10-CM	Diagnosis
E11.638	Type 2 diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E11.628	Type 2 diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E11.69	Type 2 diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E11.6	Type 2 diabetes mellitus with other specified complications	ICD-10-CM	Diagnosis
E11.630	Type 2 diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis
E11.8	Type 2 diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E11.31	Type 2 diabetes mellitus with unspecified diabetic retinopathy	ICD-10-CM	Diagnosis
E11.36	Type 2 diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E11.621	Type 2 diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E11.65	Type 2 diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E11.0	Type 2 diabetes mellitus with hyperosmolarity	ICD-10-CM	Diagnosis
E11.64	Type 2 diabetes mellitus with hypoglycemia	ICD-10-CM	Diagnosis
E11.1	Type 2 diabetes mellitus with ketoacidosis	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E11.11	Type 2 diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E11.63	Type 2 diabetes mellitus with oral complications	ICD-10-CM	Diagnosis
E11.622	Type 2 diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E11.62	Type 2 diabetes mellitus with skin complications	ICD-10-CM	Diagnosis
E11.9	Type 2 diabetes mellitus without complications	ICD-10-CM	Diagnosis
E11.359	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	ICD-10-CM	Diagnosis
E11.321	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.32	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.33	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.351	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.35	Type 2 diabetes mellitus with proliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.34	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy	ICD-10-CM	Diagnosis
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
	Acquired Hypothyroidism		
244.0	Postsurgical hypothyroidism	ICD-9-CM	Diagnosis
244.1	Other postablative hypothyroidism	ICD-9-CM	Diagnosis
244.2	Iodine hypothyroidism	ICD-9-CM	Diagnosis
244.3	Other iatrogenic hypothyroidism	ICD-9-CM	Diagnosis
244.8	Other specified acquired hypothyroidism	ICD-9-CM	Diagnosis
244.9	Unspecified hypothyroidism	ICD-9-CM	Diagnosis
E01.8	Other iodine-deficiency related thyroid disorders and allied conditions	ICD-10-CM	Diagnosis
E02	Subclinical iodine-deficiency hypothyroidism	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E03.2	Hypothyroidism due to medicaments and other exogenous substances	ICD-10-CM	Diagnosis
E03.3	Postinfectious hypothyroidism	ICD-10-CM	Diagnosis
E03.8	Other specified hypothyroidism	ICD-10-CM	Diagnosis
E03.9	Hypothyroidism, unspecified	ICD-10-CM	Diagnosis
E89.0	Postprocedural hypothyroidism	ICD-10-CM	Diagnosis
	Acute Myocardial Infarction		
410.01	Acute myocardial infarction of anterolateral wall, initial episode of care	ICD-9-CM	Diagnosis
410.11	Acute myocardial infarction of other anterior wall, initial episode of care	ICD-9-CM	Diagnosis
410.21	Acute myocardial infarction of inferolateral wall, initial episode of care	ICD-9-CM	Diagnosis
410.31	Acute myocardial infarction of inferoposterior wall, initial episode of care	ICD-9-CM	Diagnosis
410.41	Acute myocardial infarction of other inferior wall, initial episode of care	ICD-9-CM	Diagnosis
410.51	Acute myocardial infarction of other lateral wall, initial episode of care	ICD-9-CM	Diagnosis
410.61	Acute myocardial infarction, true posterior wall infarction, initial episode of care	ICD-9-CM	Diagnosis
410.71	Acute myocardial infarction, subendocardial infarction, initial episode of care	ICD-9-CM	Diagnosis
410.81	Acute myocardial infarction of other specified sites, initial episode of care	ICD-9-CM	Diagnosis
410.91	Acute myocardial infarction, unspecified site, initial episode of care	ICD-9-CM	Diagnosis
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery	ICD-10-CM	Diagnosis
I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary	ICD-10-CM	Diagnosis
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior	ICD-10-CM	Diagnosis
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery	ICD-10-CM	Diagnosis
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior	ICD-10-CM	Diagnosis
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery	ICD-10-CM	Diagnosis
I21.29	ST elevation (STEMI) myocardial infarction involving other sites	ICD-10-CM	Diagnosis
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site	ICD-10-CM	Diagnosis
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	ICD-10-CM	Diagnosis
I21.9	Acute myocardial infarction, unspecified	ICD-10-CM	Diagnosis
I21.A1	Myocardial infarction type 2	ICD-10-CM	Diagnosis
I21.A9	Other myocardial infarction type	ICD-10-CM	Diagnosis
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall	ICD-10-CM	Diagnosis
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall	ICD-10-CM	Diagnosis
I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction	ICD-10-CM	Diagnosis
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites	ICD-10-CM	Diagnosis
I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site	ICD-10-CM	Diagnosis
	Alzheimer's Disease and Related Dementias		
290.0	Senile dementia, uncomplicated	ICD-9-CM	Diagnosis
290.10	Presenile dementia, uncomplicated	ICD-9-CM	Diagnosis
290.11	Presenile dementia with delirium	ICD-9-CM	Diagnosis
290.12	Presenile dementia with delusional features	ICD-9-CM	Diagnosis
290.13	Presenile dementia with depressive features	ICD-9-CM	Diagnosis
290.20	Senile dementia with delusional features	ICD-9-CM	Diagnosis
290.21	Senile dementia with depressive features	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
290.3	Senile dementia with delirium	ICD-9-CM	Diagnosis
290.40	Vascular dementia, uncomplicated	ICD-9-CM	Diagnosis
290.41	Vascular dementia, with delirium	ICD-9-CM	Diagnosis
290.42	Vascular dementia, with delusions	ICD-9-CM	Diagnosis
290.43	Vascular dementia, with depressed mood	ICD-9-CM	Diagnosis
294.0	Amnestic disorder in conditions classified elsewhere	ICD-9-CM	Diagnosis
294.10	Dementia in conditions classified elsewhere without behavioral disturbance	ICD-9-CM	Diagnosis
294.11	Dementia in conditions classified elsewhere with behavioral disturbance	ICD-9-CM	Diagnosis
294.20	Dementia, unspecified, without behavioral disturbance	ICD-9-CM	Diagnosis
294.21	Dementia, unspecified, with behavioral disturbance	ICD-9-CM	Diagnosis
294.8	Other persistent mental disorders due to conditions classified elsewhere	ICD-9-CM	Diagnosis
331.0	Alzheimer's disease	ICD-9-CM	Diagnosis
331.11	Pick's disease	ICD-9-CM	Diagnosis
331.19	Other frontotemporal dementia	ICD-9-CM	Diagnosis
331.2	Senile degeneration of brain	ICD-9-CM	Diagnosis
331.7	Cerebral degeneration in diseases classified elsewhere	ICD-9-CM	Diagnosis
797	Senility without mention of psychosis	ICD-9-CM	Diagnosis
F01.50	Vascular dementia without behavioral disturbance	ICD-10-CM	Diagnosis
F01.51	Vascular dementia with behavioral disturbance	ICD-10-CM	Diagnosis
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance	ICD-10-CM	Diagnosis
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance	ICD-10-CM	Diagnosis
F03.90	Unspecified dementia without behavioral disturbance	ICD-10-CM	Diagnosis
F03.91	Unspecified dementia with behavioral disturbance	ICD-10-CM	Diagnosis
F04	Amnestic disorder due to known physiological condition	ICD-10-CM	Diagnosis
F05	Delirium due to known physiological condition	ICD-10-CM	Diagnosis
F06.1	Catatonic disorder due to known physiological condition	ICD-10-CM	Diagnosis
F06.8	Other specified mental disorders due to known physiological condition	ICD-10-CM	Diagnosis
G13.8	Systemic atrophy primarily affecting central nervous system in other diseases classified elsewhere	ICD-10-CM	Diagnosis
G30.0	Alzheimer's disease with early onset	ICD-10-CM	Diagnosis
G30.1	Alzheimer's disease with late onset	ICD-10-CM	Diagnosis
G30.8	Other Alzheimer's disease	ICD-10-CM	Diagnosis
G30.9	Alzheimer's disease, unspecified	ICD-10-CM	Diagnosis
G31.01	Pick's disease	ICD-10-CM	Diagnosis
G31.09	Other frontotemporal dementia	ICD-10-CM	Diagnosis
G31.1	Senile degeneration of brain, not elsewhere classified	ICD-10-CM	Diagnosis
G31.2	Degeneration of nervous system due to alcohol	ICD-10-CM	Diagnosis
G94	Other disorders of brain in diseases classified elsewhere	ICD-10-CM	Diagnosis
R41.81	Age-related cognitive decline	ICD-10-CM	Diagnosis
R54	Age-related physical debility	ICD-10-CM	Diagnosis
	Anemia		

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
280.0	Iron deficiency anemia secondary to blood loss (chronic)	ICD-9-CM	Diagnosis
280.1	Iron deficiency anemia secondary to inadequate dietary iron intake	ICD-9-CM	Diagnosis
280.8	Other specified iron deficiency anemias	ICD-9-CM	Diagnosis
280.9	Unspecified iron deficiency anemia	ICD-9-CM	Diagnosis
281.0	Pernicious anemia	ICD-9-CM	Diagnosis
281.1	Other vitamin B12 deficiency anemia	ICD-9-CM	Diagnosis
281.2	Folate-deficiency anemia	ICD-9-CM	Diagnosis
281.3	Other specified megaloblastic anemias not elsewhere classified	ICD-9-CM	Diagnosis
281.4	Protein-deficiency anemia	ICD-9-CM	Diagnosis
281.8	Anemia associated with other specified nutritional deficiency	ICD-9-CM	Diagnosis
281.9	Unspecified deficiency anemia	ICD-9-CM	Diagnosis
282.0	Hereditary spherocytosis	ICD-9-CM	Diagnosis
282.1	Hereditary elliptocytosis	ICD-9-CM	Diagnosis
282.2	Anemias due to disorders of glutathione metabolism	ICD-9-CM	Diagnosis
282.3	Other hemolytic anemias due to enzyme deficiency	ICD-9-CM	Diagnosis
282.40	Thalassemia, unspecified	ICD-9-CM	Diagnosis
282.41	Sickle-cell thalassemia without crisis	ICD-9-CM	Diagnosis
282.42	Sickle-cell thalassemia with crisis	ICD-9-CM	Diagnosis
282.43	Alpha thalassemia	ICD-9-CM	Diagnosis
282.44	Beta thalassemia	ICD-9-CM	Diagnosis
282.45	Delta-beta thalassemia	ICD-9-CM	Diagnosis
282.46	Thalassemia minor	ICD-9-CM	Diagnosis
282.47	Hemoglobin E-beta thalassemia	ICD-9-CM	Diagnosis
282.49	Other thalassemia	ICD-9-CM	Diagnosis
282.5	Sickle-cell trait	ICD-9-CM	Diagnosis
282.60	Sickle-cell disease, unspecified	ICD-9-CM	Diagnosis
282.61	Hb-SS disease without crisis	ICD-9-CM	Diagnosis
282.62	Hb-SS disease with crisis	ICD-9-CM	Diagnosis
282.63	Sickle-cell/Hb-C disease without crisis	ICD-9-CM	Diagnosis
282.64	Sickle-cell/Hb-C disease with crisis	ICD-9-CM	Diagnosis
282.68	Other sickle-cell disease without crisis	ICD-9-CM	Diagnosis
282.69	Other sickle-cell disease with crisis	ICD-9-CM	Diagnosis
282.7	Other hemoglobinopathies	ICD-9-CM	Diagnosis
282.8	Other specified hereditary hemolytic anemias	ICD-9-CM	Diagnosis
282.9	Unspecified hereditary hemolytic anemia	ICD-9-CM	Diagnosis
283.0	Autoimmune hemolytic anemias	ICD-9-CM	Diagnosis
283.10	Unspecified non-autoimmune hemolytic anemia	ICD-9-CM	Diagnosis
283.11	Hemolytic-uremic syndrome	ICD-9-CM	Diagnosis
283.19	Other non-autoimmune hemolytic anemias	ICD-9-CM	Diagnosis
283.2	Hemoglobinuria due to hemolysis from external causes	ICD-9-CM	Diagnosis
283.9	Acquired hemolytic anemia, unspecified	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
284.01	Constitutional red blood cell aplasia	ICD-9-CM	Diagnosis
284.09	Other constitutional aplastic anemia	ICD-9-CM	Diagnosis
284.11	Antineoplastic chemotherapy induced pancytopenia	ICD-9-CM	Diagnosis
284.12	Other drug induced pancytopenia	ICD-9-CM	Diagnosis
284.19	Other pancytopenia	ICD-9-CM	Diagnosis
284.2	Myelophthisis	ICD-9-CM	Diagnosis
284.81	Red cell aplasia (acquired) (adult) (with thymoma)	ICD-9-CM	Diagnosis
284.89	Other specified aplastic anemias	ICD-9-CM	Diagnosis
284.9	Unspecified aplastic anemia	ICD-9-CM	Diagnosis
285.0	Sideroblastic anemia	ICD-9-CM	Diagnosis
285.1	Acute posthemorrhagic anemia	ICD-9-CM	Diagnosis
285.21	Anemia in chronic kidney disease	ICD-9-CM	Diagnosis
285.22	Anemia in neoplastic disease	ICD-9-CM	Diagnosis
285.29	Anemia of other chronic disease	ICD-9-CM	Diagnosis
285.3	Antineoplastic chemotherapy induced anemia	ICD-9-CM	Diagnosis
285.8	Other specified anemias	ICD-9-CM	Diagnosis
285.9	Unspecified anemia	ICD-9-CM	Diagnosis
D50.0	Iron deficiency anemia secondary to blood loss (chronic)	ICD-10-CM	Diagnosis
D50.1	Sideropenic dysphagia	ICD-10-CM	Diagnosis
D50.8	Other iron deficiency anemias	ICD-10-CM	Diagnosis
D50.9	Iron deficiency anemia, unspecified	ICD-10-CM	Diagnosis
D51.0	Vitamin B12 deficiency anemia due to intrinsic factor deficiency	ICD-10-CM	Diagnosis
D51.1	Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria	ICD-10-CM	Diagnosis
D51.2	Transcobalamin II deficiency	ICD-10-CM	Diagnosis
D51.3	Other dietary vitamin B12 deficiency anemia	ICD-10-CM	Diagnosis
D51.8	Other vitamin B12 deficiency anemias	ICD-10-CM	Diagnosis
D51.9	Vitamin B12 deficiency anemia, unspecified	ICD-10-CM	Diagnosis
D52.0	Dietary folate deficiency anemia	ICD-10-CM	Diagnosis
D52.1	Drug-induced folate deficiency anemia	ICD-10-CM	Diagnosis
D52.8	Other folate deficiency anemias	ICD-10-CM	Diagnosis
D52.9	Folate deficiency anemia, unspecified	ICD-10-CM	Diagnosis
D53.0	Protein deficiency anemia	ICD-10-CM	Diagnosis
D53.1	Other megaloblastic anemias, not elsewhere classified	ICD-10-CM	Diagnosis
D53.2	Scorbutic anemia	ICD-10-CM	Diagnosis
D53.8	Other specified nutritional anemias	ICD-10-CM	Diagnosis
D53.9	Nutritional anemia, unspecified	ICD-10-CM	Diagnosis
D55.0	Anemia due to glucose-6-phosphate dehydrogenase [G6PD] deficiency	ICD-10-CM	Diagnosis
D55.1	Anemia due to other disorders of glutathione metabolism	ICD-10-CM	Diagnosis
D55.2	Anemia due to disorders of glycolytic enzymes	ICD-10-CM	Diagnosis
D55.3	Anemia due to disorders of nucleotide metabolism	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
D55.8	Other anemias due to enzyme disorders	ICD-10-CM	Diagnosis
D55.9	Anemia due to enzyme disorder, unspecified	ICD-10-CM	Diagnosis
D56.0	Alpha thalassemia	ICD-10-CM	Diagnosis
D56.1	Beta thalassemia	ICD-10-CM	Diagnosis
D56.2	Delta-beta thalassemia	ICD-10-CM	Diagnosis
D56.3	Thalassemia minor	ICD-10-CM	Diagnosis
D56.4	Hereditary persistence of fetal hemoglobin [HPFH]	ICD-10-CM	Diagnosis
D56.5	Hemoglobin E-beta thalassemia	ICD-10-CM	Diagnosis
D56.8	Other thalassemias	ICD-10-CM	Diagnosis
D56.9	Thalassemia, unspecified	ICD-10-CM	Diagnosis
D57.00	Hb-SS disease with crisis, unspecified	ICD-10-CM	Diagnosis
D57.01	Hb-SS disease with acute chest syndrome	ICD-10-CM	Diagnosis
D57.02	Hb-SS disease with splenic sequestration	ICD-10-CM	Diagnosis
D57.1	Sickle-cell disease without crisis	ICD-10-CM	Diagnosis
D57.20	Sickle-cell/Hb-C disease without crisis	ICD-10-CM	Diagnosis
D57.211	Sickle-cell/Hb-C disease with acute chest syndrome	ICD-10-CM	Diagnosis
D57.212	Sickle-cell/Hb-C disease with splenic sequestration	ICD-10-CM	Diagnosis
D57.219	Sickle-cell/Hb-C disease with crisis, unspecified	ICD-10-CM	Diagnosis
D57.3	Sickle-cell trait	ICD-10-CM	Diagnosis
D57.40	Sickle-cell thalassemia without crisis	ICD-10-CM	Diagnosis
D57.411	Sickle-cell thalassemia with acute chest syndrome	ICD-10-CM	Diagnosis
D57.412	Sickle-cell thalassemia with splenic sequestration	ICD-10-CM	Diagnosis
D57.419	Sickle-cell thalassemia with crisis, unspecified	ICD-10-CM	Diagnosis
D57.80	Other sickle-cell disorders without crisis	ICD-10-CM	Diagnosis
D57.811	Other sickle-cell disorders with acute chest syndrome	ICD-10-CM	Diagnosis
D57.812	Other sickle-cell disorders with splenic sequestration	ICD-10-CM	Diagnosis
D57.819	Other sickle-cell disorders with crisis, unspecified	ICD-10-CM	Diagnosis
D58.0	Hereditary spherocytosis	ICD-10-CM	Diagnosis
D58.1	Hereditary elliptocytosis	ICD-10-CM	Diagnosis
D58.2	Other hemoglobinopathies	ICD-10-CM	Diagnosis
D58.8	Other specified hereditary hemolytic anemias	ICD-10-CM	Diagnosis
D58.9	Hereditary hemolytic anemia, unspecified	ICD-10-CM	Diagnosis
D59.0	Drug-induced autoimmune hemolytic anemia	ICD-10-CM	Diagnosis
D59.1	Other autoimmune hemolytic anemias	ICD-10-CM	Diagnosis
D59.2	Drug-induced nonautoimmune hemolytic anemia	ICD-10-CM	Diagnosis
D59.3	Hemolytic-uremic syndrome	ICD-10-CM	Diagnosis
D59.4	Other nonautoimmune hemolytic anemias	ICD-10-CM	Diagnosis
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]	ICD-10-CM	Diagnosis
D59.6	Hemoglobinuria due to hemolysis from other external causes	ICD-10-CM	Diagnosis
D59.8	Other acquired hemolytic anemias	ICD-10-CM	Diagnosis
D59.9	Acquired hemolytic anemia, unspecified	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
D60.0	Chronic acquired pure red cell aplasia	ICD-10-CM	Diagnosis
D60.1	Transient acquired pure red cell aplasia	ICD-10-CM	Diagnosis
D60.8	Other acquired pure red cell aplasias	ICD-10-CM	Diagnosis
D60.9	Acquired pure red cell aplasia, unspecified	ICD-10-CM	Diagnosis
D61.01	Constitutional (pure) red blood cell aplasia	ICD-10-CM	Diagnosis
D61.09	Other constitutional aplastic anemia	ICD-10-CM	Diagnosis
D61.1	Drug-induced aplastic anemia	ICD-10-CM	Diagnosis
D61.2	Aplastic anemia due to other external agents	ICD-10-CM	Diagnosis
D61.3	Idiopathic aplastic anemia	ICD-10-CM	Diagnosis
D61.810	Antineoplastic chemotherapy induced pancytopenia	ICD-10-CM	Diagnosis
D61.811	Other drug-induced pancytopenia	ICD-10-CM	Diagnosis
D61.818	Other pancytopenia	ICD-10-CM	Diagnosis
D61.82	Myelophthisis	ICD-10-CM	Diagnosis
D61.89	Other specified aplastic anemias and other bone marrow failure syndromes	ICD-10-CM	Diagnosis
D61.9	Aplastic anemia, unspecified	ICD-10-CM	Diagnosis
D62	Acute posthemorrhagic anemia	ICD-10-CM	Diagnosis
D63.0	Anemia in neoplastic disease	ICD-10-CM	Diagnosis
D63.1	Anemia in chronic kidney disease	ICD-10-CM	Diagnosis
D63.8	Anemia in other chronic diseases classified elsewhere	ICD-10-CM	Diagnosis
D64.0	Hereditary sideroblastic anemia	ICD-10-CM	Diagnosis
D64.1	Secondary sideroblastic anemia due to disease	ICD-10-CM	Diagnosis
D64.2	Secondary sideroblastic anemia due to drugs and toxins	ICD-10-CM	Diagnosis
D64.3	Other sideroblastic anemias	ICD-10-CM	Diagnosis
D64.4	Congenital dyserythropoietic anemia	ICD-10-CM	Diagnosis
D64.81	Anemia due to antineoplastic chemotherapy	ICD-10-CM	Diagnosis
D64.89	Other specified anemias	ICD-10-CM	Diagnosis
D64.9	Anemia, unspecified	ICD-10-CM	Diagnosis
	Asthma		
493.00	Extrinsic asthma, unspecified	ICD-9-CM	Diagnosis
493.01	Extrinsic asthma with status asthmaticus	ICD-9-CM	Diagnosis
493.02	Extrinsic asthma, with (acute) exacerbation	ICD-9-CM	Diagnosis
493.10	Intrinsic asthma, unspecified	ICD-9-CM	Diagnosis
493.11	Intrinsic asthma with status asthmaticus	ICD-9-CM	Diagnosis
493.12	Intrinsic asthma, with (acute) exacerbation	ICD-9-CM	Diagnosis
493.20	Chronic obstructive asthma, unspecified	ICD-9-CM	Diagnosis
493.21	Chronic obstructive asthma with status asthmaticus	ICD-9-CM	Diagnosis
493.22	Chronic obstructive asthma, with (acute) exacerbation	ICD-9-CM	Diagnosis
493.81	Exercise induced bronchospasm	ICD-9-CM	Diagnosis
493.82	Cough variant asthma	ICD-9-CM	Diagnosis
493.90	Asthma, unspecified, unspecified status	ICD-9-CM	Diagnosis
493.91	Asthma, unspecified with status asthmaticus	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
493.92	Asthma, unspecified, with (acute) exacerbation	ICD-9-CM	Diagnosis
J45.20	Mild intermittent asthma, uncomplicated	ICD-10-CM	Diagnosis
J45.21	Mild intermittent asthma with (acute) exacerbation	ICD-10-CM	Diagnosis
J45.22	Mild intermittent asthma with status asthmaticus	ICD-10-CM	Diagnosis
J45.30	Mild persistent asthma, uncomplicated	ICD-10-CM	Diagnosis
J45.31	Mild persistent asthma with (acute) exacerbation	ICD-10-CM	Diagnosis
J45.32	Mild persistent asthma with status asthmaticus	ICD-10-CM	Diagnosis
J45.40	Moderate persistent asthma, uncomplicated	ICD-10-CM	Diagnosis
J45.41	Moderate persistent asthma with (acute) exacerbation	ICD-10-CM	Diagnosis
J45.42	Moderate persistent asthma with status asthmaticus	ICD-10-CM	Diagnosis
J45.50	Severe persistent asthma, uncomplicated	ICD-10-CM	Diagnosis
J45.51	Severe persistent asthma with (acute) exacerbation	ICD-10-CM	Diagnosis
J45.52	Severe persistent asthma with status asthmaticus	ICD-10-CM	Diagnosis
J45.901	Unspecified asthma with (acute) exacerbation	ICD-10-CM	Diagnosis
J45.902	Unspecified asthma with status asthmaticus	ICD-10-CM	Diagnosis
J45.909	Unspecified asthma, uncomplicated	ICD-10-CM	Diagnosis
J45.990	Exercise induced bronchospasm	ICD-10-CM	Diagnosis
J45.991	Cough variant asthma	ICD-10-CM	Diagnosis
J45.998	Other asthma	ICD-10-CM	Diagnosis
	Atrial Fibrillation		
427.31	Atrial fibrillation	ICD-9-CM	Diagnosis
I48.2	Chronic atrial fibrillation	ICD-10-CM	Diagnosis
I48.0	Paroxysmal atrial fibrillation	ICD-10-CM	Diagnosis
I48.1	Persistent atrial fibrillation	ICD-10-CM	Diagnosis
I48.91	Unspecified atrial fibrillation	ICD-10-CM	Diagnosis
	Benign Prostatic Hyperplasia		
	Benign Prostatic Hyperplasia Inclusion Codes		
600.20	Benign localized hyperplasia of prostate without urinary obstruction and other lower urinary tract symptoms [LUTS]	ICD-9-CM	Diagnosis
600.21	Benign localized hyperplasia of prostate with urinary obstruction and other lower urinary tract symptoms [LUTS]	ICD-9-CM	Diagnosis
222.2	Benign neoplasm of prostate	ICD-9-CM	Diagnosis
600.3	Cyst of prostate	ICD-9-CM	Diagnosis
600.90	Hyperplasia of prostate, unspecified, without urinary obstruction and other lower urinary tract symptoms [LUTS]	ICD-9-CM	Diagnosis
600.91	Hyperplasia of prostate, unspecified, with urinary obstruction and other lower urinary tract symptoms [LUTS]	ICD-9-CM	Diagnosis
600.00	Hypertrophy (benign) of prostate without urinary obstruction and other lower urinary tract symptoms [LUTS]	ICD-9-CM	Diagnosis
600.01	Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms [LUTS]	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
600.11	Nodular prostate with urinary obstruction	ICD-9-CM	Diagnosis
600.10	Nodular prostate without urinary obstruction	ICD-9-CM	Diagnosis
N40.1	Benign prostatic hyperplasia with lower urinary tract symptoms	ICD-10-CM	Diagnosis
N40.0	Benign prostatic hyperplasia without lower urinary tract symptoms	ICD-10-CM	Diagnosis
N42.83	Cyst of prostate	ICD-10-CM	Diagnosis
N40.2	Nodular prostate without lower urinary tract symptoms	ICD-10-CM	Diagnosis
N40.3	Nodular prostate with lower urinary tract symptoms	ICD-10-CM	Diagnosis
	Benign Prostatic Hyperplasia Exclusion Codes		
222.2	Benign neoplasm of prostate	ICD-9-CM	Diagnosis
D29.1	Benign neoplasm of prostate	ICD-10-CM	Diagnosis
	Breast Cancer		
174.0	Malignant neoplasm of nipple and areola of female breast	ICD-9-CM	Diagnosis
174.1	Malignant neoplasm of central portion of female breast	ICD-9-CM	Diagnosis
174.2	Malignant neoplasm of upper-inner quadrant of female breast	ICD-9-CM	Diagnosis
174.3	Malignant neoplasm of lower-inner quadrant of female breast	ICD-9-CM	Diagnosis
174.4	Malignant neoplasm of upper-outer quadrant of female breast	ICD-9-CM	Diagnosis
174.5	Malignant neoplasm of lower-outer quadrant of female breast	ICD-9-CM	Diagnosis
174.6	Malignant neoplasm of axillary tail of female breast	ICD-9-CM	Diagnosis
174.8	Malignant neoplasm of other specified sites of female breast	ICD-9-CM	Diagnosis
174.9	Malignant neoplasm of breast (female), unspecified site	ICD-9-CM	Diagnosis
175.0	Malignant neoplasm of nipple and areola of male breast	ICD-9-CM	Diagnosis
175.9	Malignant neoplasm of other and unspecified sites of male breast	ICD-9-CM	Diagnosis
233.0	Carcinoma in situ of breast	ICD-9-CM	Diagnosis
V10.3	Personal history of malignant neoplasm of breast	ICD-9-CM	Diagnosis
C50.011	Malignant neoplasm of nipple and areola, right female breast	ICD-10-CM	Diagnosis
C50.012	Malignant neoplasm of nipple and areola, left female breast	ICD-10-CM	Diagnosis
C50.019	Malignant neoplasm of nipple and areola, unspecified female breast	ICD-10-CM	Diagnosis
C50.021	Malignant neoplasm of nipple and areola, right male breast	ICD-10-CM	Diagnosis
C50.022	Malignant neoplasm of nipple and areola, left male breast	ICD-10-CM	Diagnosis
C50.029	Malignant neoplasm of nipple and areola, unspecified male breast	ICD-10-CM	Diagnosis
C50.111	Malignant neoplasm of central portion of right female breast	ICD-10-CM	Diagnosis
C50.112	Malignant neoplasm of central portion of left female breast	ICD-10-CM	Diagnosis
C50.119	Malignant neoplasm of central portion of unspecified female breast	ICD-10-CM	Diagnosis
C50.121	Malignant neoplasm of central portion of right male breast	ICD-10-CM	Diagnosis
C50.122	Malignant neoplasm of central portion of left male breast	ICD-10-CM	Diagnosis
C50.129	Malignant neoplasm of central portion of unspecified male breast	ICD-10-CM	Diagnosis
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast	ICD-10-CM	Diagnosis
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast	ICD-10-CM	Diagnosis
C50.219	Malignant neoplasm of upper-inner quadrant of unspecified female breast	ICD-10-CM	Diagnosis
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast	ICD-10-CM	Diagnosis
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
C50.229	Malignant neoplasm of upper-inner quadrant of unspecified male breast	ICD-10-CM	Diagnosis
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast	ICD-10-CM	Diagnosis
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast	ICD-10-CM	Diagnosis
C50.319	Malignant neoplasm of lower-inner quadrant of unspecified female breast	ICD-10-CM	Diagnosis
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast	ICD-10-CM	Diagnosis
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast	ICD-10-CM	Diagnosis
C50.329	Malignant neoplasm of lower-inner quadrant of unspecified male breast	ICD-10-CM	Diagnosis
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast	ICD-10-CM	Diagnosis
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast	ICD-10-CM	Diagnosis
C50.419	Malignant neoplasm of upper-outer quadrant of unspecified female breast	ICD-10-CM	Diagnosis
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast	ICD-10-CM	Diagnosis
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast	ICD-10-CM	Diagnosis
C50.429	Malignant neoplasm of upper-outer quadrant of unspecified male breast	ICD-10-CM	Diagnosis
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast	ICD-10-CM	Diagnosis
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast	ICD-10-CM	Diagnosis
C50.519	Malignant neoplasm of lower-outer quadrant of unspecified female breast	ICD-10-CM	Diagnosis
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast	ICD-10-CM	Diagnosis
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast	ICD-10-CM	Diagnosis
C50.529	Malignant neoplasm of lower-outer quadrant of unspecified male breast	ICD-10-CM	Diagnosis
C50.611	Malignant neoplasm of axillary tail of right female breast	ICD-10-CM	Diagnosis
C50.612	Malignant neoplasm of axillary tail of left female breast	ICD-10-CM	Diagnosis
C50.619	Malignant neoplasm of axillary tail of unspecified female breast	ICD-10-CM	Diagnosis
C50.621	Malignant neoplasm of axillary tail of right male breast	ICD-10-CM	Diagnosis
C50.622	Malignant neoplasm of axillary tail of left male breast	ICD-10-CM	Diagnosis
C50.629	Malignant neoplasm of axillary tail of unspecified male breast	ICD-10-CM	Diagnosis
C50.811	Malignant neoplasm of overlapping sites of right female breast	ICD-10-CM	Diagnosis
C50.812	Malignant neoplasm of overlapping sites of left female breast	ICD-10-CM	Diagnosis
C50.819	Malignant neoplasm of overlapping sites of unspecified female breast	ICD-10-CM	Diagnosis
C50.821	Malignant neoplasm of overlapping sites of right male breast	ICD-10-CM	Diagnosis
C50.822	Malignant neoplasm of overlapping sites of left male breast	ICD-10-CM	Diagnosis
C50.829	Malignant neoplasm of overlapping sites of unspecified male breast	ICD-10-CM	Diagnosis
C50.911	Malignant neoplasm of unspecified site of right female breast	ICD-10-CM	Diagnosis
C50.912	Malignant neoplasm of unspecified site of left female breast	ICD-10-CM	Diagnosis
C50.919	Malignant neoplasm of unspecified site of unspecified female breast	ICD-10-CM	Diagnosis
C50.921	Malignant neoplasm of unspecified site of right male breast	ICD-10-CM	Diagnosis
C50.922	Malignant neoplasm of unspecified site of left male breast	ICD-10-CM	Diagnosis
C50.929	Malignant neoplasm of unspecified site of unspecified male breast	ICD-10-CM	Diagnosis
D05.00	Lobular carcinoma in situ of unspecified breast	ICD-10-CM	Diagnosis
D05.01	Lobular carcinoma in situ of right breast	ICD-10-CM	Diagnosis
D05.02	Lobular carcinoma in situ of left breast	ICD-10-CM	Diagnosis
D05.10	Intraductal carcinoma in situ of unspecified breast	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
D05.11	Intraductal carcinoma in situ of right breast	ICD-10-CM	Diagnosis
D05.12	Intraductal carcinoma in situ of left breast	ICD-10-CM	Diagnosis
D05.80	Other specified type of carcinoma in situ of unspecified breast	ICD-10-CM	Diagnosis
D05.81	Other specified type of carcinoma in situ of right breast	ICD-10-CM	Diagnosis
D05.82	Other specified type of carcinoma in situ of left breast	ICD-10-CM	Diagnosis
D05.90	Unspecified type of carcinoma in situ of unspecified breast	ICD-10-CM	Diagnosis
D05.91	Unspecified type of carcinoma in situ of right breast	ICD-10-CM	Diagnosis
D05.92	Unspecified type of carcinoma in situ of left breast	ICD-10-CM	Diagnosis
Z85.3	Personal history of malignant neoplasm of breast	ICD-10-CM	Diagnosis
	Cataracts		
366.53	After-cataract, obscuring vision	ICD-9-CM	Diagnosis
366.01	Anterior subcapsular polar cataract, nonsenile	ICD-9-CM	Diagnosis
366.13	Anterior subcapsular polar senile cataract	ICD-9-CM	Diagnosis
379.31	Aphakia	ICD-9-CM	Diagnosis
366.46	Cataract associated with radiation and other physical influences	ICD-9-CM	Diagnosis
743.31	Congenital capsular and subcapsular cataract	ICD-9-CM	Diagnosis
743.32	Congenital cortical and zonular cataract	ICD-9-CM	Diagnosis
743.33	Congenital nuclear cataract	ICD-9-CM	Diagnosis
366.03	Cortical, lamellar, or zonular cataract, nonsenile	ICD-9-CM	Diagnosis
366.15	Cortical senile cataract	ICD-9-CM	Diagnosis
366.18	Hypermature senile cataract	ICD-9-CM	Diagnosis
366.12	Incipient cataract	ICD-9-CM	Diagnosis
V43.1	Lens replaced by other means	ICD-9-CM	Diagnosis
366.21	Localized traumatic opacities of cataract	ICD-9-CM	Diagnosis
366.04	Nuclear cataract, nonsenile	ICD-9-CM	Diagnosis
366.16	Nuclear sclerosis	ICD-9-CM	Diagnosis
366.52	Other after-cataract, not obscuring vision	ICD-9-CM	Diagnosis
366.09	Other and combined forms of nonsenile cataract	ICD-9-CM	Diagnosis
366.19	Other and combined forms of senile cataract	ICD-9-CM	Diagnosis
366.8	Other cataract	ICD-9-CM	Diagnosis
379.39	Other disorders of lens	ICD-9-CM	Diagnosis
366.23	Partially resolved traumatic cataract	ICD-9-CM	Diagnosis
366.02	Posterior subcapsular polar cataract, nonsenile	ICD-9-CM	Diagnosis
366.14	Posterior subcapsular polar senile cataract	ICD-9-CM	Diagnosis
366.51	Soemmering's ring	ICD-9-CM	Diagnosis
366.17	Total or mature senile cataract	ICD-9-CM	Diagnosis
366.22	Total traumatic cataract	ICD-9-CM	Diagnosis
366.45	Toxic cataract	ICD-9-CM	Diagnosis
366.50	Unspecified after-cataract	ICD-9-CM	Diagnosis
366.9	Unspecified cataract	ICD-9-CM	Diagnosis
366.30	Unspecified cataracta complicata	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
743.30	Unspecified congenital cataract	ICD-9-CM	Diagnosis
366.10	Unspecified senile cataract	ICD-9-CM	Diagnosis
366.20	Unspecified traumatic cataract	ICD-9-CM	Diagnosis
379.26	Vitreous prolapse	ICD-9-CM	Diagnosis
H25.23	Age-related cataract, morgagnian type, bilateral	ICD-10-CM	Diagnosis
H25.22	Age-related cataract, morgagnian type, left eye	ICD-10-CM	Diagnosis
H25.21	Age-related cataract, morgagnian type, right eye	ICD-10-CM	Diagnosis
H25.20	Age-related cataract, morgagnian type, unspecified eye	ICD-10-CM	Diagnosis
H25.13	Age-related nuclear cataract, bilateral	ICD-10-CM	Diagnosis
H25.12	Age-related nuclear cataract, left eye	ICD-10-CM	Diagnosis
H25.11	Age-related nuclear cataract, right eye	ICD-10-CM	Diagnosis
H25.10	Age-related nuclear cataract, unspecified eye	ICD-10-CM	Diagnosis
H25.033	Anterior subcapsular polar age-related cataract, bilateral	ICD-10-CM	Diagnosis
H25.032	Anterior subcapsular polar age-related cataract, left eye	ICD-10-CM	Diagnosis
H25.031	Anterior subcapsular polar age-related cataract, right eye	ICD-10-CM	Diagnosis
H25.039	Anterior subcapsular polar age-related cataract, unspecified eye	ICD-10-CM	Diagnosis
H26.043	Anterior subcapsular polar infantile and juvenile cataract, bilateral	ICD-10-CM	Diagnosis
H26.042	Anterior subcapsular polar infantile and juvenile cataract, left eye	ICD-10-CM	Diagnosis
H26.041	Anterior subcapsular polar infantile and juvenile cataract, right eye	ICD-10-CM	Diagnosis
H26.049	Anterior subcapsular polar infantile and juvenile cataract, unspecified eye	ICD-10-CM	Diagnosis
H26.213	Cataract with neovascularization, bilateral	ICD-10-CM	Diagnosis
H26.212	Cataract with neovascularization, left eye	ICD-10-CM	Diagnosis
H26.211	Cataract with neovascularization, right eye	ICD-10-CM	Diagnosis
H26.219	Cataract with neovascularization, unspecified eye	ICD-10-CM	Diagnosis
H25.819	Combined forms of age-related cataract, unspecified eye	ICD-10-CM	Diagnosis
H26.063	Combined forms of infantile and juvenile cataract, bilateral	ICD-10-CM	Diagnosis
H26.062	Combined forms of infantile and juvenile cataract, left eye	ICD-10-CM	Diagnosis
H26.061	Combined forms of infantile and juvenile cataract, right eye	ICD-10-CM	Diagnosis
H26.069	Combined forms of infantile and juvenile cataract, unspecified eye	ICD-10-CM	Diagnosis
H25.813	Combined forms of age-related cataract, bilateral	ICD-10-CM	Diagnosis
H25.812	Combined forms of age-related cataract, left eye	ICD-10-CM	Diagnosis
H25.811	Combined forms of age-related cataract, right eye	ICD-10-CM	Diagnosis
Q12.0	Congenital cataract	ICD-10-CM	Diagnosis
H25.013	Cortical age-related cataract, bilateral	ICD-10-CM	Diagnosis
H25.012	Cortical age-related cataract, left eye	ICD-10-CM	Diagnosis
H25.011	Cortical age-related cataract, right eye	ICD-10-CM	Diagnosis
H25.019	Cortical age-related cataract, unspecified eye	ICD-10-CM	Diagnosis
H26.33	Drug-induced cataract, bilateral	ICD-10-CM	Diagnosis
H26.32	Drug-induced cataract, left eye	ICD-10-CM	Diagnosis
H26.31	Drug-induced cataract, right eye	ICD-10-CM	Diagnosis
H26.30	Drug-induced cataract, unspecified eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
H26.013	Infantile and juvenile cortical, lamellar, or zonular cataract, bilateral	ICD-10-CM	Diagnosis
H26.012	Infantile and juvenile cortical, lamellar, or zonular cataract, left eye	ICD-10-CM	Diagnosis
H26.011	Infantile and juvenile cortical, lamellar, or zonular cataract, right eye	ICD-10-CM	Diagnosis
H26.019	Infantile and juvenile cortical, lamellar, or zonular cataract, unspecified eye	ICD-10-CM	Diagnosis
H26.033	Infantile and juvenile nuclear cataract, bilateral	ICD-10-CM	Diagnosis
H26.032	Infantile and juvenile nuclear cataract, left eye	ICD-10-CM	Diagnosis
H26.031	Infantile and juvenile nuclear cataract, right eye	ICD-10-CM	Diagnosis
H26.039	Infantile and juvenile nuclear cataract, unspecified eye	ICD-10-CM	Diagnosis
H26.113	Localized traumatic opacities, bilateral	ICD-10-CM	Diagnosis
H26.112	Localized traumatic opacities, left eye	ICD-10-CM	Diagnosis
H26.111	Localized traumatic opacities, right eye	ICD-10-CM	Diagnosis
H26.119	Localized traumatic opacities, unspecified eye	ICD-10-CM	Diagnosis
H25.89	Other age-related cataract	ICD-10-CM	Diagnosis
H25.093	Other age-related incipient cataract, bilateral	ICD-10-CM	Diagnosis
H25.092	Other age-related incipient cataract, left eye	ICD-10-CM	Diagnosis
H25.091	Other age-related incipient cataract, right eye	ICD-10-CM	Diagnosis
H25.099	Other age-related incipient cataract, unspecified eye	ICD-10-CM	Diagnosis
H26.09	Other infantile and juvenile cataract	ICD-10-CM	Diagnosis
H26.493	Other secondary cataract, bilateral	ICD-10-CM	Diagnosis
H26.492	Other secondary cataract, left eye	ICD-10-CM	Diagnosis
H26.491	Other secondary cataract, right eye	ICD-10-CM	Diagnosis
H26.499	Other secondary cataract, unspecified eye	ICD-10-CM	Diagnosis
H26.8	Other specified cataract	ICD-10-CM	Diagnosis
H26.123	Partially resolved traumatic cataract, bilateral	ICD-10-CM	Diagnosis
H26.122	Partially resolved traumatic cataract, left eye	ICD-10-CM	Diagnosis
H26.121	Partially resolved traumatic cataract, right eye	ICD-10-CM	Diagnosis
H26.129	Partially resolved traumatic cataract, unspecified eye	ICD-10-CM	Diagnosis
H25.043	Posterior subcapsular polar age-related cataract, bilateral	ICD-10-CM	Diagnosis
H25.042	Posterior subcapsular polar age-related cataract, left eye	ICD-10-CM	Diagnosis
H25.041	Posterior subcapsular polar age-related cataract, right eye	ICD-10-CM	Diagnosis
H25.049	Posterior subcapsular polar age-related cataract, unspecified eye	ICD-10-CM	Diagnosis
H26.053	Posterior subcapsular polar infantile and juvenile cataract, bilateral	ICD-10-CM	Diagnosis
H26.052	Posterior subcapsular polar infantile and juvenile cataract, left eye	ICD-10-CM	Diagnosis
H26.051	Posterior subcapsular polar infantile and juvenile cataract, right eye	ICD-10-CM	Diagnosis
H26.059	Posterior subcapsular polar infantile and juvenile cataract, unspecified eye	ICD-10-CM	Diagnosis
Z96.1	Presence of intraocular lens	ICD-10-CM	Diagnosis
H26.413	Soemmering's ring, bilateral	ICD-10-CM	Diagnosis
H26.412	Soemmering's ring, left eye	ICD-10-CM	Diagnosis
H26.411	Soemmering's ring, right eye	ICD-10-CM	Diagnosis
H26.419	Soemmering's ring, unspecified eye	ICD-10-CM	Diagnosis
H26.133	Total traumatic cataract, bilateral	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
H26.132	Total traumatic cataract, left eye	ICD-10-CM	Diagnosis
H26.131	Total traumatic cataract, right eye	ICD-10-CM	Diagnosis
H26.139	Total traumatic cataract, unspecified eye	ICD-10-CM	Diagnosis
H25.9	Unspecified age-related cataract	ICD-10-CM	Diagnosis
H26.9	Unspecified cataract	ICD-10-CM	Diagnosis
H26.20	Unspecified complicated cataract	ICD-10-CM	Diagnosis
H26.40	Unspecified secondary cataract	ICD-10-CM	Diagnosis
H26.103	Unspecified traumatic cataract, bilateral	ICD-10-CM	Diagnosis
H26.102	Unspecified traumatic cataract, left eye	ICD-10-CM	Diagnosis
H26.101	Unspecified traumatic cataract, right eye	ICD-10-CM	Diagnosis
H26.109	Unspecified traumatic cataract, unspecified eye	ICD-10-CM	Diagnosis
	Chronic Kidney Disease		
584.8	Acute kidney failure with other specified pathological lesion in kidney	ICD-9-CM	Diagnosis
580.81	Acute glomerulonephritis with other specified pathological lesion in kidney in disease classified elsewhere	ICD-9-CM	Diagnosis
580.9	Acute glomerulonephritis with unspecified pathological lesion in kidney	ICD-9-CM	Diagnosis
580	Acute glomerulonephritis with lesion of proliferative glomerulonephritis	ICD-9-CM	Diagnosis
580.4	Acute glomerulonephritis with lesion of rapidly progressive glomerulonephritis	ICD-9-CM	Diagnosis
584.9	Acute kidney failure, unspecified	ICD-9-CM	Diagnosis
584.6	Acute kidney failure with lesion of renal cortical necrosis	ICD-9-CM	Diagnosis
584.7	Acute kidney failure with lesion of medullary [papillary] necrosis	ICD-9-CM	Diagnosis
584.5	Acute kidney failure with lesion of tubular necrosis	ICD-9-CM	Diagnosis
442.1	Aneurysm of renal artery	ICD-9-CM	Diagnosis
440.1	Atherosclerosis of renal artery	ICD-9-CM	Diagnosis
223	Benign neoplasm of kidney, except pelvis	ICD-9-CM	Diagnosis
582.89	Other chronic glomerulonephritis with specified pathological lesion in kidney	ICD-9-CM	Diagnosis
582.81	Chronic glomerulonephritis with other specified pathological lesion in kidney in diseases classified elsewhere	ICD-9-CM	Diagnosis
582.1	Chronic glomerulonephritis with lesion of membranous glomerulonephritis	ICD-9-CM	Diagnosis
582.2	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis	ICD-9-CM	Diagnosis
582	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis	ICD-9-CM	Diagnosis
582.4	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis	ICD-9-CM	Diagnosis
582.9	Chronic glomerulonephritis with unspecified pathological lesion in kidney	ICD-9-CM	Diagnosis
585.1	Chronic kidney disease, Stage I	ICD-9-CM	Diagnosis
585.2	Chronic kidney disease, Stage II (mild)	ICD-9-CM	Diagnosis
585.3	Chronic kidney disease, Stage III (moderate)	ICD-9-CM	Diagnosis
585.4	Chronic kidney disease, Stage IV (severe)	ICD-9-CM	Diagnosis
585.5	Chronic kidney disease, Stage V	ICD-9-CM	Diagnosis
585.9	Chronic kidney disease, unspecified	ICD-9-CM	Diagnosis
753.16	Congenital medullary cystic kidney	ICD-9-CM	Diagnosis
753.17	Congenital medullary sponge kidney	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
753.21	Congenital obstruction of ureteropelvic junction	ICD-9-CM	Diagnosis
753.22	Congenital obstruction of ureterovesical junction	ICD-9-CM	Diagnosis
753.13	Congenital polycystic kidney, autosomal dominant	ICD-9-CM	Diagnosis
753.14	Congenital polycystic kidney, autosomal recessive	ICD-9-CM	Diagnosis
753.12	Congenital polycystic kidney, unspecified type	ICD-9-CM	Diagnosis
753.15	Congenital renal dysplasia	ICD-9-CM	Diagnosis
753.23	Congenital ureterocele	ICD-9-CM	Diagnosis
250.43	Diabetes with renal manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.41	Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.4	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.42	Diabetes with renal manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
585.6	End stage renal disease	ICD-9-CM	Diagnosis
274.1	Gouty nephropathy, unspecified	ICD-9-CM	Diagnosis
283.11	Hemolytic-uremic syndrome	ICD-9-CM	Diagnosis
572.4	Hepatorenal syndrome	ICD-9-CM	Diagnosis
403.01	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
403.11	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
403.91	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.02	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.12	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.92	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
591	Hydronephrosis	ICD-9-CM	Diagnosis
189	Malignant neoplasm of kidney, except pelvis	ICD-9-CM	Diagnosis
189.9	Malignant neoplasm of urinary organ, site unspecified	ICD-9-CM	Diagnosis
236.91	Neoplasm of uncertain behavior of kidney and ureter	ICD-9-CM	Diagnosis
583.6	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal cortical necrosis	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
583.81	Nephritis and nephropathy, not specified as acute or chronic, with other specified pathological lesion in kidney, in diseases classified elsewhere	ICD-9-CM	Diagnosis
583.7	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal medullary necrosis	ICD-9-CM	Diagnosis
583.2	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranoproliferative glomerulonephritis	ICD-9-CM	Diagnosis
583.4	Nephritis and nephropathy, not specified as acute or chronic, with lesion of rapidly progressive glomerulonephritis	ICD-9-CM	Diagnosis
583.89	Other nephritis and nephropathy, not specified as acute or chronic, with specified pathological lesion in kidney	ICD-9-CM	Diagnosis
583	Nephritis and nephropathy, not specified as acute or chronic, with lesion of proliferative glomerulonephritis	ICD-9-CM	Diagnosis
583.9	Nephritis and nephropathy, not specified as acute or chronic, with unspecified pathological lesion in kidney	ICD-9-CM	Diagnosis
583.1	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranous glomerulonephritis	ICD-9-CM	Diagnosis
588.1	Nephrogenic diabetes insipidus	ICD-9-CM	Diagnosis
581.3	Nephrotic syndrome with lesion of minimal change glomerulonephritis	ICD-9-CM	Diagnosis
581.2	Nephrotic syndrome with lesion of membranoproliferative glomerulonephritis	ICD-9-CM	Diagnosis
581.81	Nephrotic syndrome with other specified pathological lesion in kidney in diseases classified elsewhere	ICD-9-CM	Diagnosis
581.1	Nephrotic syndrome with lesion of membranous glomerulonephritis	ICD-9-CM	Diagnosis
581	Nephrotic syndrome with lesion of proliferative glomerulonephritis	ICD-9-CM	Diagnosis
581.9	Nephrotic syndrome with unspecified pathological lesion in kidney	ICD-9-CM	Diagnosis
794.4	Nonspecific abnormal results of kidney function study	ICD-9-CM	Diagnosis
580.89	Other acute glomerulonephritis with other specified pathological lesion in kidney	ICD-9-CM	Diagnosis
581.89	Other nephrotic syndrome with specified pathological lesion in kidney	ICD-9-CM	Diagnosis
588.89	Other specified disorders resulting from impaired renal function	ICD-9-CM	Diagnosis
753.29	Other obstructive defect of renal pelvis and ureter	ICD-9-CM	Diagnosis
753.19	Other specified congenital cystic kidney disease	ICD-9-CM	Diagnosis
271.4	Renal glycosuria	ICD-9-CM	Diagnosis
588	Renal osteodystrophy	ICD-9-CM	Diagnosis
249.4	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.41	Secondary diabetes mellitus with renal manifestations, uncontrolled	ICD-9-CM	Diagnosis
588.81	Secondary hyperparathyroidism (of renal origin)	ICD-9-CM	Diagnosis
95.4	Syphilis of kidney	ICD-9-CM	Diagnosis
16.02	Tuberculosis of kidney, bacteriological or histological examination unknown (at present)	ICD-9-CM	Diagnosis
16.01	Tuberculosis of kidney, bacteriological or histological examination not done	ICD-9-CM	Diagnosis
16.04	Tuberculosis of kidney, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
16.05	Tuberculosis of kidney, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically	ICD-9-CM	Diagnosis
16.06	Tuberculosis of kidney, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods [inoculation of animals]	ICD-9-CM	Diagnosis
16.03	Tuberculosis of kidney, tubercle bacilli found (in sputum) by microscopy	ICD-9-CM	Diagnosis
16	Tuberculosis of kidney, confirmation unspecified	ICD-9-CM	Diagnosis
588.9	Unspecified disorder resulting from impaired renal function	ICD-9-CM	Diagnosis
753.2	Unspecified obstructive defect of renal pelvis and ureter	ICD-9-CM	Diagnosis
586	Unspecified renal failure	ICD-9-CM	Diagnosis
587	Unspecified renal sclerosis	ICD-9-CM	Diagnosis
R94.4	Abnormal results of kidney function studies	ICD-10-CM	Diagnosis
N00.4	Acute nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N00.3	Acute nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N00.5	Acute nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N17.9	Acute kidney failure, unspecified	ICD-10-CM	Diagnosis
N17.1	Acute kidney failure with acute cortical necrosis	ICD-10-CM	Diagnosis
N17.2	Acute kidney failure with medullary necrosis	ICD-10-CM	Diagnosis
N00.6	Acute nephritic syndrome with dense deposit disease	ICD-10-CM	Diagnosis
N00.7	Acute nephritic syndrome with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N00.1	Acute nephritic syndrome with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N00.0	Acute nephritic syndrome with minor glomerular abnormality	ICD-10-CM	Diagnosis
N00.8	Acute nephritic syndrome with other morphologic changes	ICD-10-CM	Diagnosis
N00.9	Acute nephritic syndrome with unspecified morphologic changes	ICD-10-CM	Diagnosis
N00.2	Acute nephritic syndrome with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N17.0	Acute kidney failure with tubular necrosis	ICD-10-CM	Diagnosis
N14.0	Analgesic nephropathy	ICD-10-CM	Diagnosis
I72.2	Aneurysm of renal artery	ICD-10-CM	Diagnosis
I70.1	Atherosclerosis of renal artery	ICD-10-CM	Diagnosis
N26.1	Atrophy of kidney (terminal)	ICD-10-CM	Diagnosis
N15.0	Balkan nephropathy	ICD-10-CM	Diagnosis
D30.02	Benign neoplasm of left kidney	ICD-10-CM	Diagnosis
D30.01	Benign neoplasm of right kidney	ICD-10-CM	Diagnosis
D30.00	Benign neoplasm of unspecified kidney	ICD-10-CM	Diagnosis
Q62.32	Cecoureterocele	ICD-10-CM	Diagnosis
N03.3	Chronic nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N03.4	Chronic nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N18.1	Chronic kidney disease, stage 1	ICD-10-CM	Diagnosis
N18.2	Chronic kidney disease, stage 2 (mild)	ICD-10-CM	Diagnosis
N18.3	Chronic kidney disease, stage 3 (moderate)	ICD-10-CM	Diagnosis
N18.4	Chronic kidney disease, stage 4 (severe)	ICD-10-CM	Diagnosis
N18.5	Chronic kidney disease, stage 5	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
N18.9	Chronic kidney disease, unspecified	ICD-10-CM	Diagnosis
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N03.6	Chronic nephritic syndrome with dense deposit disease	ICD-10-CM	Diagnosis
N03.7	Chronic nephritic syndrome with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N03.5	Chronic nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N03.0	Chronic nephritic syndrome with minor glomerular abnormality	ICD-10-CM	Diagnosis
N03.8	Chronic nephritic syndrome with other morphologic changes	ICD-10-CM	Diagnosis
N03.9	Chronic nephritic syndrome with unspecified morphologic changes	ICD-10-CM	Diagnosis
N03.2	Chronic nephritic syndrome with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
Q62.0	Congenital hydronephrosis	ICD-10-CM	Diagnosis
Q62.2	Congenital megaureter	ICD-10-CM	Diagnosis
Q61.02	Congenital multiple renal cysts	ICD-10-CM	Diagnosis
Q62.10	Congenital occlusion of ureter, unspecified	ICD-10-CM	Diagnosis
Q62.11	Congenital occlusion of ureteropelvic junction	ICD-10-CM	Diagnosis
Q62.12	Congenital occlusion of ureterovesical orifice	ICD-10-CM	Diagnosis
Q62.31	Congenital ureterocele, orthotopic	ICD-10-CM	Diagnosis
Q61.11	Cystic dilatation of collecting ducts	ICD-10-CM	Diagnosis
N25.9	Disorder resulting from impaired renal tubular function, unspecified	ICD-10-CM	Diagnosis
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication	ICD-10-CM	Diagnosis
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy	ICD-10-CM	Diagnosis
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia	ICD-10-CM	Diagnosis
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E09.29	Drug or chemical induced diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
N18.6	End stage renal disease	ICD-10-CM	Diagnosis
M32.14	Glomerular disease in systemic lupus erythematosus	ICD-10-CM	Diagnosis
N08	Glomerular disorders in diseases classified elsewhere	ICD-10-CM	Diagnosis
M10.372	Gout due to renal impairment, left ankle and foot	ICD-10-CM	Diagnosis
M10.322	Gout due to renal impairment, left elbow	ICD-10-CM	Diagnosis
M10.342	Gout due to renal impairment, left hand	ICD-10-CM	Diagnosis
M10.352	Gout due to renal impairment, left hip	ICD-10-CM	Diagnosis
M10.362	Gout due to renal impairment, left knee	ICD-10-CM	Diagnosis
M10.312	Gout due to renal impairment, left shoulder	ICD-10-CM	Diagnosis
M10.332	Gout due to renal impairment, left wrist	ICD-10-CM	Diagnosis
M10.39	Gout due to renal impairment, multiple sites	ICD-10-CM	Diagnosis
M10.371	Gout due to renal impairment, right ankle and foot	ICD-10-CM	Diagnosis
M10.321	Gout due to renal impairment, right elbow	ICD-10-CM	Diagnosis
M10.341	Gout due to renal impairment, right hand	ICD-10-CM	Diagnosis
M10.351	Gout due to renal impairment, right hip	ICD-10-CM	Diagnosis
M10.361	Gout due to renal impairment, right knee	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M10.311	Gout due to renal impairment, right shoulder	ICD-10-CM	Diagnosis
M10.331	Gout due to renal impairment, right wrist	ICD-10-CM	Diagnosis
M10.379	Gout due to renal impairment, unspecified ankle and foot	ICD-10-CM	Diagnosis
M10.319	Gout due to renal impairment, unspecified shoulder	ICD-10-CM	Diagnosis
M10.329	Gout due to renal impairment, unspecified elbow	ICD-10-CM	Diagnosis
M10.349	Gout due to renal impairment, unspecified hand	ICD-10-CM	Diagnosis
M10.359	Gout due to renal impairment, unspecified hip	ICD-10-CM	Diagnosis
M10.369	Gout due to renal impairment, unspecified knee	ICD-10-CM	Diagnosis
M10.30	Gout due to renal impairment, unspecified site	ICD-10-CM	Diagnosis
M10.339	Gout due to renal impairment, unspecified wrist	ICD-10-CM	Diagnosis
M10.38	Gout due to renal impairment, vertebrae	ICD-10-CM	Diagnosis
D59.3	Hemolytic-uremic syndrome	ICD-10-CM	Diagnosis
K76.7	Hepatorenal syndrome	ICD-10-CM	Diagnosis
N07.3	Hereditary nephropathy, not elsewhere classified with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N07.1	Hereditary nephropathy, not elsewhere classified with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N07.6	Hereditary nephropathy, not elsewhere classified with dense deposit disease	ICD-10-CM	Diagnosis
N07.4	Hereditary nephropathy, not elsewhere classified with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N07.7	Hereditary nephropathy, not elsewhere classified with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N07.2	Hereditary nephropathy, not elsewhere classified with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N07.5	Hereditary nephropathy, not elsewhere classified with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N07.0	Hereditary nephropathy, not elsewhere classified with minor glomerular abnormality	ICD-10-CM	Diagnosis
N07.8	Hereditary nephropathy, not elsewhere classified with other morphologic lesions	ICD-10-CM	Diagnosis
N07.9	Hereditary nephropathy, not elsewhere classified with unspecified morphologic lesions	ICD-10-CM	Diagnosis
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	ICD-10-CM	Diagnosis
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis
I13.10	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis
I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease	ICD-10-CM	Diagnosis
N13.2	Hydronephrosis with renal and ureteral calculous obstruction	ICD-10-CM	Diagnosis
N13.1	Hydronephrosis with ureteral stricture, not elsewhere classified	ICD-10-CM	Diagnosis
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	ICD-10-CM	Diagnosis
N06.8	Isolated proteinuria with other morphologic lesion	ICD-10-CM	Diagnosis
N06.3	Isolated proteinuria with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N06.7	Isolated proteinuria with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N06.4	Isolated proteinuria with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N06.2	Isolated proteinuria with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N06.5	Isolated proteinuria with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N06.1	Isolated proteinuria with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N06.0	Isolated proteinuria with minor glomerular abnormality	ICD-10-CM	Diagnosis
N06.9	Isolated proteinuria with unspecified morphologic lesion	ICD-10-CM	Diagnosis
N06.6	Isolated proteinuria with dense deposit disease	ICD-10-CM	Diagnosis
C64.2	Malignant neoplasm of left kidney, except renal pelvis	ICD-10-CM	Diagnosis
C68.9	Malignant neoplasm of urinary organ, unspecified	ICD-10-CM	Diagnosis
C64.1	Malignant neoplasm of right kidney, except renal pelvis	ICD-10-CM	Diagnosis
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis	ICD-10-CM	Diagnosis
Q61.5	Medullary cystic kidney	ICD-10-CM	Diagnosis
D41.12	Neoplasm of uncertain behavior of left renal pelvis	ICD-10-CM	Diagnosis
D41.02	Neoplasm of uncertain behavior of left kidney	ICD-10-CM	Diagnosis
D41.22	Neoplasm of uncertain behavior of left ureter	ICD-10-CM	Diagnosis
D41.01	Neoplasm of uncertain behavior of right kidney	ICD-10-CM	Diagnosis
D41.21	Neoplasm of uncertain behavior of right ureter	ICD-10-CM	Diagnosis
D41.11	Neoplasm of uncertain behavior of right renal pelvis	ICD-10-CM	Diagnosis
D41.00	Neoplasm of uncertain behavior of unspecified kidney	ICD-10-CM	Diagnosis
D41.10	Neoplasm of uncertain behavior of unspecified renal pelvis	ICD-10-CM	Diagnosis
D41.20	Neoplasm of uncertain behavior of unspecified ureter	ICD-10-CM	Diagnosis
N25.1	Nephrogenic diabetes insipidus	ICD-10-CM	Diagnosis
N14.3	Nephropathy induced by heavy metals	ICD-10-CM	Diagnosis
N14.1	Nephropathy induced by other drugs, medicaments and biological substances	ICD-10-CM	Diagnosis
N14.2	Nephropathy induced by unspecified drug, medicament or biological substance	ICD-10-CM	Diagnosis
N04.4	Nephrotic syndrome with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N04.3	Nephrotic syndrome with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N04.5	Nephrotic syndrome with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N04.8	Nephrotic syndrome with other morphologic changes	ICD-10-CM	Diagnosis
N04.7	Nephrotic syndrome with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N04.2	Nephrotic syndrome with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N04.1	Nephrotic syndrome with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N04.0	Nephrotic syndrome with minor glomerular abnormality	ICD-10-CM	Diagnosis
N04.9	Nephrotic syndrome with unspecified morphologic changes	ICD-10-CM	Diagnosis
N04.6	Nephrotic syndrome with dense deposit disease	ICD-10-CM	Diagnosis
N25.89	Other disorders resulting from impaired renal tubular function	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E13.21	Other specified diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E13.29	Other specified diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
N17.8	Other acute kidney failure	ICD-10-CM	Diagnosis
Q61.8	Other cystic kidney diseases	ICD-10-CM	Diagnosis
N13.39	Other hydronephrosis	ICD-10-CM	Diagnosis
Q62.39	Other obstructive defects of renal pelvis and ureter	ICD-10-CM	Diagnosis
Q61.19	Other polycystic kidney, infantile type	ICD-10-CM	Diagnosis
N15.8	Other specified renal tubulo-interstitial diseases	ICD-10-CM	Diagnosis
E74.8	Other specified disorders of carbohydrate metabolism	ICD-10-CM	Diagnosis
B52.0	Plasmodium malariae malaria with nephropathy	ICD-10-CM	Diagnosis
Q61.2	Polycystic kidney, adult type	ICD-10-CM	Diagnosis
Q61.3	Polycystic kidney, unspecified	ICD-10-CM	Diagnosis
N01.3	Rapidly progressive nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N01.4	Rapidly progressive nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N01.1	Rapidly progressive nephritic syndrome with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N01.6	Rapidly progressive nephritic syndrome with dense deposit disease	ICD-10-CM	Diagnosis
N01.5	Rapidly progressive nephritic syndrome with diffuse mesangiocapillary	ICD-10-CM	Diagnosis
N01.7	Rapidly progressive nephritic syndrome with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N01.2	Rapidly progressive nephritic syndrome with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N01.0	Rapidly progressive nephritic syndrome with minor glomerular abnormality	ICD-10-CM	Diagnosis
N01.8	Rapidly progressive nephritic syndrome with other morphologic changes	ICD-10-CM	Diagnosis
N01.9	Rapidly progressive nephritic syndrome with unspecified morphologic changes	ICD-10-CM	Diagnosis
N02.3	Recurrent and persistent hematuria with diffuse mesangial proliferative	ICD-10-CM	Diagnosis
N02.1	Recurrent and persistent hematuria with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N02.6	Recurrent and persistent hematuria with dense deposit disease	ICD-10-CM	Diagnosis
N02.4	Recurrent and persistent hematuria with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N02.7	Recurrent and persistent hematuria with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N02.5	Recurrent and persistent hematuria with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N02.8	Recurrent and persistent hematuria with other morphologic changes	ICD-10-CM	Diagnosis
N02.9	Recurrent and persistent hematuria with unspecified morphologic changes	ICD-10-CM	Diagnosis
N02.0	Recurrent and persistent hematuria with minor glomerular abnormality	ICD-10-CM	Diagnosis
N02.2	Recurrent and persistent hematuria with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
Q61.4	Renal dysplasia	ICD-10-CM	Diagnosis
N25.0	Renal osteodystrophy	ICD-10-CM	Diagnosis
N26.9	Renal sclerosis, unspecified	ICD-10-CM	Diagnosis
N16	Renal tubulo-interstitial disorders in diseases classified elsewhere	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
N15.9	Renal tubulo-interstitial disease, unspecified	ICD-10-CM	Diagnosis
N25.81	Secondary hyperparathyroidism of renal origin	ICD-10-CM	Diagnosis
M35.04	Sicca syndrome with tubulo-interstitial nephropathy	ICD-10-CM	Diagnosis
A52.75	Syphilis of kidney and ureter	ICD-10-CM	Diagnosis
N14.4	Toxic nephropathy, not elsewhere classified	ICD-10-CM	Diagnosis
A18.11	Tuberculosis of kidney and ureter	ICD-10-CM	Diagnosis
M32.15	Tubulo-interstitial nephropathy in systemic lupus erythematosus	ICD-10-CM	Diagnosis
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E10.21	Type 1 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E10.65	Type 1 diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E11.21	Type 2 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E11.65	Type 2 diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
N05.4	Unspecified nephritic syndrome with diffuse endocapillary proliferative	ICD-10-CM	Diagnosis
N05.3	Unspecified nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N05.5	Unspecified nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N05.1	Unspecified nephritic syndrome with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N05.6	Unspecified nephritic syndrome with dense deposit disease	ICD-10-CM	Diagnosis
N05.7	Unspecified nephritic syndrome with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N05.2	Unspecified nephritic syndrome with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N05.0	Unspecified nephritic syndrome with minor glomerular abnormality	ICD-10-CM	Diagnosis
N05.8	Unspecified nephritic syndrome with other morphologic changes	ICD-10-CM	Diagnosis
N05.9	Unspecified nephritic syndrome with unspecified morphologic changes	ICD-10-CM	Diagnosis
N13.30	Unspecified hydronephrosis	ICD-10-CM	Diagnosis
N19	Unspecified kidney failure	ICD-10-CM	Diagnosis
	Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis		
490	Bronchitis, not specified as acute or chronic	ICD-9-CM	Diagnosis
491.0	Simple chronic bronchitis	ICD-9-CM	Diagnosis
491.1	Mucopurulent chronic bronchitis	ICD-9-CM	Diagnosis
491.20	Obstructive chronic bronchitis, without exacerbation	ICD-9-CM	Diagnosis
491.21	Obstructive chronic bronchitis, with (acute) exacerbation	ICD-9-CM	Diagnosis
491.22	Obstructive chronic bronchitis with acute bronchitis	ICD-9-CM	Diagnosis
491.8	Other chronic bronchitis	ICD-9-CM	Diagnosis
491.9	Unspecified chronic bronchitis	ICD-9-CM	Diagnosis
492.0	Emphysematous bleb	ICD-9-CM	Diagnosis
492.8	Other emphysema	ICD-9-CM	Diagnosis
494.0	Bronchiectasis without acute exacerbation	ICD-9-CM	Diagnosis
494.1	Bronchiectasis with acute exacerbation	ICD-9-CM	Diagnosis
496	Chronic airway obstruction, not elsewhere classified	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
J40	Bronchitis, not specified as acute or chronic	ICD-10-CM	Diagnosis
J41.0	Simple chronic bronchitis	ICD-10-CM	Diagnosis
J41.1	Mucopurulent chronic bronchitis	ICD-10-CM	Diagnosis
J41.8	Mixed simple and mucopurulent chronic bronchitis	ICD-10-CM	Diagnosis
J42	Unspecified chronic bronchitis	ICD-10-CM	Diagnosis
J43.0	Unilateral pulmonary emphysema [MacLeod's syndrome]	ICD-10-CM	Diagnosis
J43.1	Panlobular emphysema	ICD-10-CM	Diagnosis
J43.2	Centrilobular emphysema	ICD-10-CM	Diagnosis
J43.8	Other emphysema	ICD-10-CM	Diagnosis
J43.9	Emphysema, unspecified	ICD-10-CM	Diagnosis
J44.0	Chronic obstructive pulmonary disease with acute lower respiratory infection	ICD-10-CM	Diagnosis
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation	ICD-10-CM	Diagnosis
J44.9	Chronic obstructive pulmonary disease, unspecified	ICD-10-CM	Diagnosis
J47.0	Bronchiectasis with acute lower respiratory infection	ICD-10-CM	Diagnosis
J47.1	Bronchiectasis with (acute) exacerbation	ICD-10-CM	Diagnosis
J47.9	Bronchiectasis, uncomplicated	ICD-10-CM	Diagnosis
	Colorectal Cancer		
153.0	Malignant neoplasm of hepatic flexure	ICD-9-CM	Diagnosis
153.1	Malignant neoplasm of transverse colon	ICD-9-CM	Diagnosis
153.2	Malignant neoplasm of descending colon	ICD-9-CM	Diagnosis
153.3	Malignant neoplasm of sigmoid colon	ICD-9-CM	Diagnosis
153.4	Malignant neoplasm of cecum	ICD-9-CM	Diagnosis
153.5	Malignant neoplasm of appendix	ICD-9-CM	Diagnosis
153.6	Malignant neoplasm of ascending colon	ICD-9-CM	Diagnosis
153.7	Malignant neoplasm of splenic flexure	ICD-9-CM	Diagnosis
153.8	Malignant neoplasm of other specified sites of large intestine	ICD-9-CM	Diagnosis
153.9	Malignant neoplasm of colon, unspecified site	ICD-9-CM	Diagnosis
154.0	Malignant neoplasm of rectosigmoid junction	ICD-9-CM	Diagnosis
154.1	Malignant neoplasm of rectum	ICD-9-CM	Diagnosis
230.3	Carcinoma in situ of colon	ICD-9-CM	Diagnosis
230.4	Carcinoma in situ of rectum	ICD-9-CM	Diagnosis
V10.05	Personal history of malignant neoplasm of large intestine	ICD-9-CM	Diagnosis
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus	ICD-9-CM	Diagnosis
C18.0	Malignant neoplasm of cecum	ICD-10-CM	Diagnosis
C18.1	Malignant neoplasm of appendix	ICD-10-CM	Diagnosis
C18.2	Malignant neoplasm of ascending colon	ICD-10-CM	Diagnosis
C18.3	Malignant neoplasm of hepatic flexure	ICD-10-CM	Diagnosis
C18.4	Malignant neoplasm of transverse colon	ICD-10-CM	Diagnosis
C18.5	Malignant neoplasm of splenic flexure	ICD-10-CM	Diagnosis
C18.6	Malignant neoplasm of descending colon	ICD-10-CM	Diagnosis
C18.7	Malignant neoplasm of sigmoid colon	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
C18.8	Malignant neoplasm of overlapping sites of colon	ICD-10-CM	Diagnosis
C18.9	Malignant neoplasm of colon, unspecified	ICD-10-CM	Diagnosis
C19	Malignant neoplasm of rectosigmoid junction	ICD-10-CM	Diagnosis
C20	Malignant neoplasm of rectum	ICD-10-CM	Diagnosis
D01.0	Carcinoma in situ of colon	ICD-10-CM	Diagnosis
D01.1	Carcinoma in situ of rectosigmoid junction	ICD-10-CM	Diagnosis
D01.2	Carcinoma in situ of rectum	ICD-10-CM	Diagnosis
Z85.038	Personal history of other malignant neoplasm of large intestine	ICD-10-CM	Diagnosis
Z85.040	Personal history of malignant carcinoid tumor of rectum	ICD-10-CM	Diagnosis
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and	ICD-10-CM	Diagnosis
	Depression		
296.20	Major depressive disorder, single episode, unspecified	ICD-9-CM	Diagnosis
296.21	Major depressive disorder, single episode, mild	ICD-9-CM	Diagnosis
296.22	Major depressive disorder, single episode, moderate	ICD-9-CM	Diagnosis
296.23	Major depressive disorder, single episode, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.24	Major depressive disorder, single episode, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.25	Major depressive disorder, single episode, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.26	Major depressive disorder, single episode in full remission	ICD-9-CM	Diagnosis
296.30	Major depressive disorder, recurrent episode, unspecified	ICD-9-CM	Diagnosis
296.31	Major depressive disorder, recurrent episode, mild	ICD-9-CM	Diagnosis
296.32	Major depressive disorder, recurrent episode, moderate	ICD-9-CM	Diagnosis
296.33	Major depressive disorder, recurrent episode, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.34	Major depressive disorder, recurrent episode, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.35	Major depressive disorder, recurrent episode, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.36	Major depressive disorder, recurrent episode, in full remission	ICD-9-CM	Diagnosis
296.51	Bipolar I disorder, most recent episode (or current) depressed, mild	ICD-9-CM	Diagnosis
296.52	Bipolar I disorder, most recent episode (or current) depressed, moderate	ICD-9-CM	Diagnosis
296.53	Bipolar I disorder, most recent episode (or current) depressed, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.54	Bipolar I disorder, most recent episode (or current) depressed, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.55	Bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.56	Bipolar I disorder, most recent episode (or current) depressed, in full remission	ICD-9-CM	Diagnosis
296.60	Bipolar I disorder, most recent episode (or current) mixed, unspecified	ICD-9-CM	Diagnosis
296.61	Bipolar I disorder, most recent episode (or current) mixed, mild	ICD-9-CM	Diagnosis
296.62	Bipolar I disorder, most recent episode (or current) mixed, moderate	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
296.63	Bipolar I disorder, most recent episode (or current) mixed, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.64	Bipolar I disorder, most recent episode (or current) mixed, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.65	Bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.66	Bipolar I disorder, most recent episode (or current) mixed, in full remission	ICD-9-CM	Diagnosis
296.89	Other and unspecified bipolar disorders	ICD-9-CM	Diagnosis
298.0	Depressive type psychosis	ICD-9-CM	Diagnosis
300.4	Dysthymic disorder	ICD-9-CM	Diagnosis
309.1	Prolonged depressive reaction as adjustment reaction	ICD-9-CM	Diagnosis
311	Depressive disorder, not elsewhere classified	ICD-9-CM	Diagnosis
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified	ICD-10-CM	Diagnosis
F31.31	Bipolar disorder, current episode depressed, mild	ICD-10-CM	Diagnosis
F31.32	Bipolar disorder, current episode depressed, moderate	ICD-10-CM	Diagnosis
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features	ICD-10-CM	Diagnosis
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features	ICD-10-CM	Diagnosis
F31.60	Bipolar disorder, current episode mixed, unspecified	ICD-10-CM	Diagnosis
F31.61	Bipolar disorder, current episode mixed, mild	ICD-10-CM	Diagnosis
F31.62	Bipolar disorder, current episode mixed, moderate	ICD-10-CM	Diagnosis
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features	ICD-10-CM	Diagnosis
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features	ICD-10-CM	Diagnosis
F31.75	Bipolar disorder, in partial remission, most recent episode depressed	ICD-10-CM	Diagnosis
F31.76	Bipolar disorder, in full remission, most recent episode depressed	ICD-10-CM	Diagnosis
F31.77	Bipolar disorder, in partial remission, most recent episode mixed	ICD-10-CM	Diagnosis
F31.78	Bipolar disorder, in full remission, most recent episode mixed	ICD-10-CM	Diagnosis
F31.81	Bipolar II disorder	ICD-10-CM	Diagnosis
F32.0	Major depressive disorder, single episode, mild	ICD-10-CM	Diagnosis
F32.1	Major depressive disorder, single episode, moderate	ICD-10-CM	Diagnosis
F32.2	Major depressive disorder, single episode, severe without psychotic features	ICD-10-CM	Diagnosis
F32.3	Major depressive disorder, single episode, severe with psychotic features	ICD-10-CM	Diagnosis
F32.4	Major depressive disorder, single episode, in partial remission	ICD-10-CM	Diagnosis
F32.5	Major depressive disorder, single episode, in full remission	ICD-10-CM	Diagnosis
F32.9	Major depressive disorder, single episode, unspecified	ICD-10-CM	Diagnosis
F33.0	Major depressive disorder, recurrent, mild	ICD-10-CM	Diagnosis
F33.1	Major depressive disorder, recurrent, moderate	ICD-10-CM	Diagnosis
F33.2	Major depressive disorder, recurrent severe without psychotic features	ICD-10-CM	Diagnosis
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	ICD-10-CM	Diagnosis
F33.40	Major depressive disorder, recurrent, in remission, unspecified	ICD-10-CM	Diagnosis
F33.41	Major depressive disorder, recurrent, in partial remission	ICD-10-CM	Diagnosis
F33.42	Major depressive disorder, recurrent, in full remission	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
F33.8	Other recurrent depressive disorders	ICD-10-CM	Diagnosis
F33.9	Major depressive disorder, recurrent, unspecified	ICD-10-CM	Diagnosis
F34.1	Dysthymic disorder	ICD-10-CM	Diagnosis
F43.21	Adjustment disorder with depressed mood	ICD-10-CM	Diagnosis
F43.23	Adjustment disorder with mixed anxiety and depressed mood	ICD-10-CM	Diagnosis
	Diabetes		
249.00	Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.01	Secondary diabetes mellitus without mention of complication, uncontrolled	ICD-9-CM	Diagnosis
249.10	Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or	ICD-9-CM	Diagnosis
249.11	Secondary diabetes mellitus with ketoacidosis, uncontrolled	ICD-9-CM	Diagnosis
249.20	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or	ICD-9-CM	Diagnosis
249.21	Secondary diabetes mellitus with hyperosmolarity, uncontrolled	ICD-9-CM	Diagnosis
249.30	Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.31	Secondary diabetes mellitus with other coma, uncontrolled	ICD-9-CM	Diagnosis
249.40	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.41	Secondary diabetes mellitus with renal manifestations, uncontrolled	ICD-9-CM	Diagnosis
249.50	Secondary diabetes mellitus with ophthalmic manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.51	Secondary diabetes mellitus with ophthalmic manifestations, uncontrolled	ICD-9-CM	Diagnosis
249.60	Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.61	Secondary diabetes mellitus with neurological manifestations, uncontrolled	ICD-9-CM	Diagnosis
249.70	Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.71	Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled	ICD-9-CM	Diagnosis
249.80	Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.81	Secondary diabetes mellitus with other specified manifestations, uncontrolled	ICD-9-CM	Diagnosis
249.90	Secondary diabetes mellitus with unspecified complication, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.91	Secondary diabetes mellitus with unspecified complication, uncontrolled	ICD-9-CM	Diagnosis
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.01	Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.02	Diabetes mellitus without mention of complication, type II or unspecified type,	ICD-9-CM	Diagnosis
250.03	Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.10	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
250.11	Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.12	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.13	Diabetes with ketoacidosis, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.20	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.21	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.22	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.23	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.30	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.31	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.32	Diabetes with other coma, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.33	Diabetes with other coma, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.40	Diabetes with renal manifestations, type II or unspecified type, not stated as	ICD-9-CM	Diagnosis
250.41	Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.42	Diabetes with renal manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.43	Diabetes with renal manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.50	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.51	Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.52	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.53	Diabetes with ophthalmic manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.60	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.61	Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.62	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.63	Diabetes with neurological manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.70	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.71	Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.72	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.73	Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.80	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.81	Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.82	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.83	Diabetes with other specified manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
250.90	Diabetes with unspecified complication, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.91	Diabetes with unspecified complication, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.92	Diabetes with unspecified complication, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.93	Diabetes with unspecified complication, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
357.2	Polyneuropathy in diabetes	ICD-9-CM	Diagnosis
362.01	Background diabetic retinopathy	ICD-9-CM	Diagnosis
362.02	Proliferative diabetic retinopathy	ICD-9-CM	Diagnosis
362.03	Nonproliferative diabetic retinopathy NOS	ICD-9-CM	Diagnosis
362.04	Mild nonproliferative diabetic retinopathy	ICD-9-CM	Diagnosis
362.05	Moderate nonproliferative diabetic retinopathy	ICD-9-CM	Diagnosis
362.06	Severe nonproliferative diabetic retinopathy	ICD-9-CM	Diagnosis
366.41	Diabetic cataract	ICD-9-CM	Diagnosis
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	ICD-10-CM	Diagnosis
E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma	ICD-10-CM	Diagnosis
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma	ICD-10-CM	Diagnosis
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma	ICD-10-CM	Diagnosis
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy	ICD-10-CM	Diagnosis
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication	ICD-10-CM	Diagnosis
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.321	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3219	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.329	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.3291	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E08.3292	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E08.3293	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3299	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.331	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3319	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.339	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.3391	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E08.3392	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E08.3393	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3399	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.341	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3419	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.349	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.3491	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E08.3492	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E08.3493	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3499	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.351	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3519	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis
E08.3529	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis
E08.3539	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E08.3549	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E08.3559	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis
E08.359	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3599	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract	ICD-10-CM	Diagnosis
E08.37X1	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, right eye	ICD-10-CM	Diagnosis
E08.37X2	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, left eye	ICD-10-CM	Diagnosis
E08.37X3	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, bilateral	ICD-10-CM	Diagnosis
E08.37X9	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E08.39	Diabetes mellitus due to underlying condition with other diabetic ophthalmic	ICD-10-CM	Diagnosis
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy	ICD-10-CM	Diagnosis
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication	ICD-10-CM	Diagnosis
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E08.59	Diabetes mellitus due to underlying condition with other circulatory complications	ICD-10-CM	Diagnosis
E08.610	Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E08.618	Diabetes mellitus due to underlying condition with other diabetic arthropathy	ICD-10-CM	Diagnosis
E08.620	Diabetes mellitus due to underlying condition with diabetic dermatitis	ICD-10-CM	Diagnosis
E08.621	Diabetes mellitus due to underlying condition with foot ulcer	ICD-10-CM	Diagnosis
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer	ICD-10-CM	Diagnosis
E08.628	Diabetes mellitus due to underlying condition with other skin complications	ICD-10-CM	Diagnosis
E08.630	Diabetes mellitus due to underlying condition with periodontal disease	ICD-10-CM	Diagnosis
E08.638	Diabetes mellitus due to underlying condition with other oral complications	ICD-10-CM	Diagnosis
E08.641	Diabetes mellitus due to underlying condition with hypoglycemia with coma	ICD-10-CM	Diagnosis
E08.649	Diabetes mellitus due to underlying condition with hypoglycemia without coma	ICD-10-CM	Diagnosis
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia	ICD-10-CM	Diagnosis
E08.69	Diabetes mellitus due to underlying condition with other specified complication	ICD-10-CM	Diagnosis
E08.8	Diabetes mellitus due to underlying condition with unspecified complications	ICD-10-CM	Diagnosis
E08.9	Diabetes mellitus due to underlying condition without complications	ICD-10-CM	Diagnosis
E09.00	Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	ICD-10-CM	Diagnosis
E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma	ICD-10-CM	Diagnosis
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E09.11	Drug or chemical induced diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E09.29	Drug or chemical induced diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E09.311	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.319	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E09.321	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.3211	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E09.3212	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E09.3213	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3219	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.329	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E09.3291	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E09.3292	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E09.3293	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3299	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.331	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.3311	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E09.3312	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E09.3313	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3319	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.339	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E09.3391	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E09.3392	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E09.3393	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3399	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.341	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.3411	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E09.3412	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E09.3413	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3419	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.349	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E09.3491	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E09.3492	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E09.3493	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3499	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.351	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.3511	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E09.3512	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E09.3513	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3519	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.3521	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E09.3522	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E09.3523	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis
E09.3529	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E09.3531	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E09.3532	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E09.3533	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis
E09.3539	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E09.3541	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E09.3542	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E09.3543	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E09.3549	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E09.3551	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E09.3552	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E09.3553	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E09.3559	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis
E09.359	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E09.3591	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E09.3592	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E09.3593	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3599	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E09.37X1	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	ICD-10-CM	Diagnosis
E09.37X2	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, left eye	ICD-10-CM	Diagnosis
E09.37X3	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	ICD-10-CM	Diagnosis
E09.37X9	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E09.39	Drug or chemical induced diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E09.44	Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy	ICD-10-CM	Diagnosis
E09.49	Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication	ICD-10-CM	Diagnosis
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E09.52	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E09.59	Drug or chemical induced diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis
E09.610	Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E09.618	Drug or chemical induced diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E09.620	Drug or chemical induced diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E09.628	Drug or chemical induced diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E09.630	Drug or chemical induced diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis
E09.638	Drug or chemical induced diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E09.641	Drug or chemical induced diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E09.649	Drug or chemical induced diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E09.69	Drug or chemical induced diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E09.9	Drug or chemical induced diabetes mellitus without complications	ICD-10-CM	Diagnosis
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E10.21	Type 1 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.321	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E10.3219	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.329	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.3291	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3292	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.3293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3299	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3319	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.339	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.3391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3392	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.3393	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3399	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.341	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E10.3419	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.349	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.3493	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3499	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.351	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3519	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.36	Type 1 diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E10.37X1	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	ICD-10-CM	Diagnosis
E10.37X2	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye	ICD-10-CM	Diagnosis
E10.37X3	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	ICD-10-CM	Diagnosis
E10.37X9	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy	ICD-10-CM	Diagnosis
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication	ICD-10-CM	Diagnosis
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E10.59	Type 1 diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E10.618	Type 1 diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E10.620	Type 1 diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E10.621	Type 1 diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E10.622	Type 1 diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E10.628	Type 1 diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E10.630	Type 1 diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis
E10.638	Type 1 diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E10.641	Type 1 diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E10.65	Type 1 diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E10.69	Type 1 diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E10.8	Type 1 diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E10.9	Type 1 diabetes mellitus without complications	ICD-10-CM	Diagnosis
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	ICD-10-CM	Diagnosis
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma	ICD-10-CM	Diagnosis
E11.10	Type 2 diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E11.11	Type 2 diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E11.21	Type 2 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.321	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3219	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.3291	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E11.3293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3299	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3319	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3392	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E11.3393	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3399	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3419	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.3491	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3492	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis

Code	Description	Code Type	Code Category
E11.3493	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3499	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.351	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema,	ICD-10-CM	Diagnosis
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3519	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis
E11.3529	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis
E11.3539	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E11.3549	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E11.3559	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E11.359	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3599	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.36	Type 2 diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E11.37X1	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	ICD-10-CM	Diagnosis
E11.37X2	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left	ICD-10-CM	Diagnosis
E11.37X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	ICD-10-CM	Diagnosis
E11.37X9	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy	ICD-10-CM	Diagnosis
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication	ICD-10-CM	Diagnosis
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E11.59	Type 2 diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E11.620	Type 2 diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E11.621	Type 2 diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E11.622	Type 2 diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E11.628	Type 2 diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E11.630	Type 2 diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis
E11.638	Type 2 diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E11.641	Type 2 diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E11.65	Type 2 diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E11.69	Type 2 diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E11.8	Type 2 diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E11.9	Type 2 diabetes mellitus without complications	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E13.00	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	ICD-10-CM	Diagnosis
E13.01	Other specified diabetes mellitus with hyperosmolarity with coma	ICD-10-CM	Diagnosis
E13.10	Other specified diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E13.11	Other specified diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E13.21	Other specified diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E13.29	Other specified diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E13.311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E13.319	Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E13.321	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E13.3211	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E13.3212	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E13.3213	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3219	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.329	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E13.3291	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E13.3292	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E13.3293	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3299	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.331	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E13.3311	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E13.3312	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E13.3313	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E13.3319	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.339	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E13.3391	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E13.3392	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E13.3393	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3399	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.341	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E13.3411	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E13.3412	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E13.3413	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3419	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.349	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E13.3491	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E13.3492	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E13.3493	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3499	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.351	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E13.3511	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E13.3512	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E13.3513	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis

Code	Description	Code Type	Code Category
E13.3519	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.3521	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E13.3522	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E13.3523	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis
E13.3529	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E13.3531	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E13.3532	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E13.3533	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis
E13.3539	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E13.3541	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E13.3542	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis
E13.3543	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E13.3549	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E13.3551	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E13.3552	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E13.3553	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E13.3559	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis
E13.359	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E13.36	Other specified diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E13.39	Other specified diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E13.40	Other specified diabetes mellitus with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E13.44	Other specified diabetes mellitus with diabetic amyotrophy	ICD-10-CM	Diagnosis
E13.49	Other specified diabetes mellitus with other diabetic neurological complication	ICD-10-CM	Diagnosis
E13.51	Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E13.52	Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E13.59	Other specified diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis
E13.610	Other specified diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E13.618	Other specified diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E13.620	Other specified diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E13.621	Other specified diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E13.622	Other specified diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E13.628	Other specified diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E13.630	Other specified diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis
E13.638	Other specified diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E13.641	Other specified diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E13.649	Other specified diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E13.65	Other specified diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E13.69	Other specified diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E13.8	Other specified diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E13.9	Other specified diabetes mellitus without complications	ICD-10-CM	Diagnosis
	Endometrial Cancer		
182	Malignant neoplasm of corpus uteri, except isthmus	ICD-9-CM	Diagnosis
233.2	Carcinoma in situ of other and unspecified parts of uterus	ICD-9-CM	Diagnosis
V10.42	Personal history of malignant neoplasm of other parts of the uterus	ICD-9-CM	Diagnosis
C54.1	Malignant neoplasm of endometrium	ICD-10-CM	Diagnosis
C54.2	Malignant neoplasm of myometrium	ICD-10-CM	Diagnosis
C54.3	Malignant neoplasm of fundus uteri	ICD-10-CM	Diagnosis
C54.8	Malignant neoplasm of overlapping sites of corpus uteri	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
C54.9	Malignant neoplasm of corpus uteri, unspecified	ICD-10-CM	Diagnosis
D07.0	Carcinoma in situ of endometrium	ICD-10-CM	Diagnosis
Z85.42	Personal history of malignant neoplasm of other parts of uterus	ICD-10-CM	Diagnosis
	Glaucoma		
362.85	Retinal nerve fiber bundle defects	ICD-9-CM	Diagnosis
365.00	Unspecified preglaucoma	ICD-9-CM	Diagnosis
365.01	Borderline glaucoma, open angle with borderline findings, low risk	ICD-9-CM	Diagnosis
365.02	Borderline glaucoma with anatomical narrow angle	ICD-9-CM	Diagnosis
365.03	Borderline glaucoma with steroid responders	ICD-9-CM	Diagnosis
365.04	Borderline glaucoma with ocular hypertension	ICD-9-CM	Diagnosis
365.10	Unspecified open-angle glaucoma	ICD-9-CM	Diagnosis
365.11	Primary open-angle glaucoma	ICD-9-CM	Diagnosis
365.12	Low tension open-angle glaucoma	ICD-9-CM	Diagnosis
365.13	Pigmentary open-angle glaucoma	ICD-9-CM	Diagnosis
365.15	Residual stage of open angle glaucoma	ICD-9-CM	Diagnosis
365.20	Unspecified primary angle-closure glaucoma	ICD-9-CM	Diagnosis
365.21	Intermittent angle-closure glaucoma	ICD-9-CM	Diagnosis
365.22	Acute angle-closure glaucoma	ICD-9-CM	Diagnosis
365.23	Chronic angle-closure glaucoma	ICD-9-CM	Diagnosis
365.24	Residual stage of angle-closure glaucoma	ICD-9-CM	Diagnosis
365.31	Corticosteroid-induced glaucoma, glaucomatous stage	ICD-9-CM	Diagnosis
365.32	Corticosteroid-induced glaucoma, residual stage	ICD-9-CM	Diagnosis
365.41	Glaucoma associated with chamber angle anomalies	ICD-9-CM	Diagnosis
365.42	Glaucoma associated with anomalies of iris	ICD-9-CM	Diagnosis
365.43	Glaucoma associated with other anterior segment anomalies	ICD-9-CM	Diagnosis
365.51	Phacolytic glaucoma	ICD-9-CM	Diagnosis
365.52	Pseudoexfoliation glaucoma	ICD-9-CM	Diagnosis
365.59	Glaucoma associated with other lens disorders	ICD-9-CM	Diagnosis
365.60	Glaucoma associated with unspecified ocular disorder	ICD-9-CM	Diagnosis
365.61	Glaucoma associated with pupillary block	ICD-9-CM	Diagnosis
365.62	Glaucoma associated with ocular inflammations	ICD-9-CM	Diagnosis
365.63	Glaucoma associated with vascular disorders of eye	ICD-9-CM	Diagnosis
365.64	Glaucoma associated with tumors or cysts	ICD-9-CM	Diagnosis
365.65	Glaucoma associated with ocular trauma	ICD-9-CM	Diagnosis
365.81	Hypersecretion glaucoma	ICD-9-CM	Diagnosis
365.82	Glaucoma with increased episcleral venous pressure	ICD-9-CM	Diagnosis
365.83	Aqueous misdirection	ICD-9-CM	Diagnosis
365.89	Other specified glaucoma	ICD-9-CM	Diagnosis
365.9	Unspecified glaucoma	ICD-9-CM	Diagnosis
377.14	Glaucomatous atrophy (cupping) of optic disc	ICD-9-CM	Diagnosis
H40.001	Preglaucoma, unspecified, right eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
H40.002	Preglaucoma, unspecified, left eye	ICD-10-CM	Diagnosis
H40.003	Preglaucoma, unspecified, bilateral	ICD-10-CM	Diagnosis
H40.009	Preglaucoma, unspecified, unspecified eye	ICD-10-CM	Diagnosis
H40.011	Open angle with borderline findings, low risk, right eye	ICD-10-CM	Diagnosis
H40.012	Open angle with borderline findings, low risk, left eye	ICD-10-CM	Diagnosis
H40.013	Open angle with borderline findings, low risk, bilateral	ICD-10-CM	Diagnosis
H40.019	Open angle with borderline findings, low risk, unspecified eye	ICD-10-CM	Diagnosis
H40.031	Anatomical narrow angle, right eye	ICD-10-CM	Diagnosis
H40.032	Anatomical narrow angle, left eye	ICD-10-CM	Diagnosis
H40.033	Anatomical narrow angle, bilateral	ICD-10-CM	Diagnosis
H40.039	Anatomical narrow angle, unspecified eye	ICD-10-CM	Diagnosis
H40.041	Steroid responder, right eye	ICD-10-CM	Diagnosis
H40.042	Steroid responder, left eye	ICD-10-CM	Diagnosis
H40.043	Steroid responder, bilateral	ICD-10-CM	Diagnosis
H40.049	Steroid responder, unspecified eye	ICD-10-CM	Diagnosis
H40.051	Ocular hypertension, right eye	ICD-10-CM	Diagnosis
H40.052	Ocular hypertension, left eye	ICD-10-CM	Diagnosis
H40.053	Ocular hypertension, bilateral	ICD-10-CM	Diagnosis
H40.059	Ocular hypertension, unspecified eye	ICD-10-CM	Diagnosis
H40.10X0	Unspecified open-angle glaucoma, stage unspecified	ICD-10-CM	Diagnosis
H40.10X1	Unspecified open-angle glaucoma, mild stage	ICD-10-CM	Diagnosis
H40.10X2	Unspecified open-angle glaucoma, moderate stage	ICD-10-CM	Diagnosis
H40.10X3	Unspecified open-angle glaucoma, severe stage	ICD-10-CM	Diagnosis
H40.10X4	Unspecified open-angle glaucoma, indeterminate stage	ICD-10-CM	Diagnosis
H40.1110	Primary open-angle glaucoma, right eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1111	Primary open-angle glaucoma, right eye, mild stage	ICD-10-CM	Diagnosis
H40.1112	Primary open-angle glaucoma, right eye, moderate stage	ICD-10-CM	Diagnosis
H40.1113	Primary open-angle glaucoma, right eye, severe stage	ICD-10-CM	Diagnosis
H40.1114	Primary open-angle glaucoma, right eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1120	Primary open-angle glaucoma, left eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1121	Primary open-angle glaucoma, left eye, mild stage	ICD-10-CM	Diagnosis
H40.1122	Primary open-angle glaucoma, left eye, moderate stage	ICD-10-CM	Diagnosis
H40.1123	Primary open-angle glaucoma, left eye, severe stage	ICD-10-CM	Diagnosis
H40.1124	Primary open-angle glaucoma, left eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1130	Primary open-angle glaucoma, bilateral, stage unspecified	ICD-10-CM	Diagnosis
H40.1131	Primary open-angle glaucoma, bilateral, mild stage	ICD-10-CM	Diagnosis
H40.1132	Primary open-angle glaucoma, bilateral, moderate stage	ICD-10-CM	Diagnosis
H40.1133	Primary open-angle glaucoma, bilateral, severe stage	ICD-10-CM	Diagnosis
H40.1134	Primary open-angle glaucoma, bilateral, indeterminate stage	ICD-10-CM	Diagnosis
H40.1190	Primary open-angle glaucoma, unspecified eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1191	Primary open-angle glaucoma, unspecified eye, mild stage	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
H40.1192	Primary open-angle glaucoma, unspecified eye, moderate stage	ICD-10-CM	Diagnosis
H40.1193	Primary open-angle glaucoma, unspecified eye, severe stage	ICD-10-CM	Diagnosis
H40.1194	Primary open-angle glaucoma, unspecified eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.11X0	Primary open-angle glaucoma, stage unspecified	ICD-10-CM	Diagnosis
H40.11X1	Primary open-angle glaucoma, mild stage	ICD-10-CM	Diagnosis
H40.11X2	Primary open-angle glaucoma, moderate stage	ICD-10-CM	Diagnosis
H40.11X3	Primary open-angle glaucoma, severe stage	ICD-10-CM	Diagnosis
H40.11X4	Primary open-angle glaucoma, indeterminate stage	ICD-10-CM	Diagnosis
H40.1210	Low-tension glaucoma, right eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1211	Low-tension glaucoma, right eye, mild stage	ICD-10-CM	Diagnosis
H40.1212	Low-tension glaucoma, right eye, moderate stage	ICD-10-CM	Diagnosis
H40.1213	Low-tension glaucoma, right eye, severe stage	ICD-10-CM	Diagnosis
H40.1214	Low-tension glaucoma, right eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1220	Low-tension glaucoma, left eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1221	Low-tension glaucoma, left eye, mild stage	ICD-10-CM	Diagnosis
H40.1222	Low-tension glaucoma, left eye, moderate stage	ICD-10-CM	Diagnosis
H40.1223	Low-tension glaucoma, left eye, severe stage	ICD-10-CM	Diagnosis
H40.1224	Low-tension glaucoma, left eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1230	Low-tension glaucoma, bilateral, stage unspecified	ICD-10-CM	Diagnosis
H40.1231	Low-tension glaucoma, bilateral, mild stage	ICD-10-CM	Diagnosis
H40.1232	Low-tension glaucoma, bilateral, moderate stage	ICD-10-CM	Diagnosis
H40.1233	Low-tension glaucoma, bilateral, severe stage	ICD-10-CM	Diagnosis
H40.1234	Low-tension glaucoma, bilateral, indeterminate stage	ICD-10-CM	Diagnosis
H40.1290	Low-tension glaucoma, unspecified eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1291	Low-tension glaucoma, unspecified eye, mild stage	ICD-10-CM	Diagnosis
H40.1292	Low-tension glaucoma, unspecified eye, moderate stage	ICD-10-CM	Diagnosis
H40.1293	Low-tension glaucoma, unspecified eye, severe stage	ICD-10-CM	Diagnosis
H40.1294	Low-tension glaucoma, unspecified eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1310	Pigmentary glaucoma, right eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1311	Pigmentary glaucoma, right eye, mild stage	ICD-10-CM	Diagnosis
H40.1312	Pigmentary glaucoma, right eye, moderate stage	ICD-10-CM	Diagnosis
H40.1313	Pigmentary glaucoma, right eye, severe stage	ICD-10-CM	Diagnosis
H40.1314	Pigmentary glaucoma, right eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1320	Pigmentary glaucoma, left eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1321	Pigmentary glaucoma, left eye, mild stage	ICD-10-CM	Diagnosis
H40.1322	Pigmentary glaucoma, left eye, moderate stage	ICD-10-CM	Diagnosis
H40.1323	Pigmentary glaucoma, left eye, severe stage	ICD-10-CM	Diagnosis
H40.1324	Pigmentary glaucoma, left eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1330	Pigmentary glaucoma, bilateral, stage unspecified	ICD-10-CM	Diagnosis
H40.1331	Pigmentary glaucoma, bilateral, mild stage	ICD-10-CM	Diagnosis
H40.1332	Pigmentary glaucoma, bilateral, moderate stage	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
H40.1333	Pigmentary glaucoma, bilateral, severe stage	ICD-10-CM	Diagnosis
H40.1334	Pigmentary glaucoma, bilateral, indeterminate stage	ICD-10-CM	Diagnosis
H40.1390	Pigmentary glaucoma, unspecified eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1391	Pigmentary glaucoma, unspecified eye, mild stage	ICD-10-CM	Diagnosis
H40.1392	Pigmentary glaucoma, unspecified eye, moderate stage	ICD-10-CM	Diagnosis
H40.1393	Pigmentary glaucoma, unspecified eye, severe stage	ICD-10-CM	Diagnosis
H40.1394	Pigmentary glaucoma, unspecified eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1410	Capsular glaucoma with pseudoexfoliation of lens, right eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1411	Capsular glaucoma with pseudoexfoliation of lens, right eye, mild stage	ICD-10-CM	Diagnosis
H40.1412	Capsular glaucoma with pseudoexfoliation of lens, right eye, moderate stage	ICD-10-CM	Diagnosis
H40.1413	Capsular glaucoma with pseudoexfoliation of lens, right eye, severe stage	ICD-10-CM	Diagnosis
H40.1414	Capsular glaucoma with pseudoexfoliation of lens, right eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1420	Capsular glaucoma with pseudoexfoliation of lens, left eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1421	Capsular glaucoma with pseudoexfoliation of lens, left eye, mild stage	ICD-10-CM	Diagnosis
H40.1422	Capsular glaucoma with pseudoexfoliation of lens, left eye, moderate stage	ICD-10-CM	Diagnosis
H40.1423	Capsular glaucoma with pseudoexfoliation of lens, left eye, severe stage	ICD-10-CM	Diagnosis
H40.1424	Capsular glaucoma with pseudoexfoliation of lens, left eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.1430	Capsular glaucoma with pseudoexfoliation of lens, bilateral, stage unspecified	ICD-10-CM	Diagnosis
H40.1431	Capsular glaucoma with pseudoexfoliation of lens, bilateral, mild stage	ICD-10-CM	Diagnosis
H40.1432	Capsular glaucoma with pseudoexfoliation of lens, bilateral, moderate stage	ICD-10-CM	Diagnosis
H40.1433	Capsular glaucoma with pseudoexfoliation of lens, bilateral, severe stage	ICD-10-CM	Diagnosis
H40.1434	Capsular glaucoma with pseudoexfoliation of lens, bilateral, indeterminate stage	ICD-10-CM	Diagnosis
H40.1490	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, stage unspecified	ICD-10-CM	Diagnosis
H40.1491	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, mild stage	ICD-10-CM	Diagnosis
H40.1492	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, moderate stage	ICD-10-CM	Diagnosis
H40.1493	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, severe stage	ICD-10-CM	Diagnosis
H40.1494	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.151	Residual stage of open-angle glaucoma, right eye	ICD-10-CM	Diagnosis
H40.152	Residual stage of open-angle glaucoma, left eye	ICD-10-CM	Diagnosis
H40.153	Residual stage of open-angle glaucoma, bilateral	ICD-10-CM	Diagnosis
H40.159	Residual stage of open-angle glaucoma, unspecified eye	ICD-10-CM	Diagnosis
H40.20X0	Unspecified primary angle-closure glaucoma, stage unspecified	ICD-10-CM	Diagnosis
H40.20X1	Unspecified primary angle-closure glaucoma, mild stage	ICD-10-CM	Diagnosis
H40.20X2	Unspecified primary angle-closure glaucoma, moderate stage	ICD-10-CM	Diagnosis
H40.20X3	Unspecified primary angle-closure glaucoma, severe stage	ICD-10-CM	Diagnosis
H40.20X4	Unspecified primary angle-closure glaucoma, indeterminate stage	ICD-10-CM	Diagnosis
H40.211	Acute angle-closure glaucoma, right eye	ICD-10-CM	Diagnosis
H40.212	Acute angle-closure glaucoma, left eye	ICD-10-CM	Diagnosis
H40.213	Acute angle-closure glaucoma, bilateral	ICD-10-CM	Diagnosis
H40.219	Acute angle-closure glaucoma, unspecified eye	ICD-10-CM	Diagnosis
H40.2210	Chronic angle-closure glaucoma, right eye, stage unspecified	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
H40.2211	Chronic angle-closure glaucoma, right eye, mild stage	ICD-10-CM	Diagnosis
H40.2212	Chronic angle-closure glaucoma, right eye, moderate stage	ICD-10-CM	Diagnosis
H40.2213	Chronic angle-closure glaucoma, right eye, severe stage	ICD-10-CM	Diagnosis
H40.2214	Chronic angle-closure glaucoma, right eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.2220	Chronic angle-closure glaucoma, left eye, stage unspecified	ICD-10-CM	Diagnosis
H40.2221	Chronic angle-closure glaucoma, left eye, mild stage	ICD-10-CM	Diagnosis
H40.2222	Chronic angle-closure glaucoma, left eye, moderate stage	ICD-10-CM	Diagnosis
H40.2223	Chronic angle-closure glaucoma, left eye, severe stage	ICD-10-CM	Diagnosis
H40.2224	Chronic angle-closure glaucoma, left eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.2230	Chronic angle-closure glaucoma, bilateral, stage unspecified	ICD-10-CM	Diagnosis
H40.2231	Chronic angle-closure glaucoma, bilateral, mild stage	ICD-10-CM	Diagnosis
H40.2232	Chronic angle-closure glaucoma, bilateral, moderate stage	ICD-10-CM	Diagnosis
H40.2233	Chronic angle-closure glaucoma, bilateral, severe stage	ICD-10-CM	Diagnosis
H40.2234	Chronic angle-closure glaucoma, bilateral, indeterminate stage	ICD-10-CM	Diagnosis
H40.2290	Chronic angle-closure glaucoma, unspecified eye, stage unspecified	ICD-10-CM	Diagnosis
H40.2291	Chronic angle-closure glaucoma, unspecified eye, mild stage	ICD-10-CM	Diagnosis
H40.2292	Chronic angle-closure glaucoma, unspecified eye, moderate stage	ICD-10-CM	Diagnosis
H40.2293	Chronic angle-closure glaucoma, unspecified eye, severe stage	ICD-10-CM	Diagnosis
H40.2294	Chronic angle-closure glaucoma, unspecified eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.231	Intermittent angle-closure glaucoma, right eye	ICD-10-CM	Diagnosis
H40.232	Intermittent angle-closure glaucoma, left eye	ICD-10-CM	Diagnosis
H40.233	Intermittent angle-closure glaucoma, bilateral	ICD-10-CM	Diagnosis
H40.239	Intermittent angle-closure glaucoma, unspecified eye	ICD-10-CM	Diagnosis
H40.241	Residual stage of angle-closure glaucoma, right eye	ICD-10-CM	Diagnosis
H40.242	Residual stage of angle-closure glaucoma, left eye	ICD-10-CM	Diagnosis
H40.243	Residual stage of angle-closure glaucoma, bilateral	ICD-10-CM	Diagnosis
H40.249	Residual stage of angle-closure glaucoma, unspecified eye	ICD-10-CM	Diagnosis
H40.30X0	Glaucoma secondary to eye trauma, unspecified eye, stage unspecified	ICD-10-CM	Diagnosis
H40.30X1	Glaucoma secondary to eye trauma, unspecified eye, mild stage	ICD-10-CM	Diagnosis
H40.30X2	Glaucoma secondary to eye trauma, unspecified eye, moderate stage	ICD-10-CM	Diagnosis
H40.30X3	Glaucoma secondary to eye trauma, unspecified eye, severe stage	ICD-10-CM	Diagnosis
H40.30X4	Glaucoma secondary to eye trauma, unspecified eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.31X0	Glaucoma secondary to eye trauma, right eye, stage unspecified	ICD-10-CM	Diagnosis
H40.31X1	Glaucoma secondary to eye trauma, right eye, mild stage	ICD-10-CM	Diagnosis
H40.31X2	Glaucoma secondary to eye trauma, right eye, moderate stage	ICD-10-CM	Diagnosis
H40.31X3	Glaucoma secondary to eye trauma, right eye, severe stage	ICD-10-CM	Diagnosis
H40.31X4	Glaucoma secondary to eye trauma, right eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.32X0	Glaucoma secondary to eye trauma, left eye, stage unspecified	ICD-10-CM	Diagnosis
H40.32X1	Glaucoma secondary to eye trauma, left eye, mild stage	ICD-10-CM	Diagnosis
H40.32X2	Glaucoma secondary to eye trauma, left eye, moderate stage	ICD-10-CM	Diagnosis
H40.32X3	Glaucoma secondary to eye trauma, left eye, severe stage	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
H40.33X0	Glaucoma secondary to eye trauma, bilateral, stage unspecified	ICD-10-CM	Diagnosis
H40.33X1	Glaucoma secondary to eye trauma, bilateral, mild stage	ICD-10-CM	Diagnosis
H40.33X2	Glaucoma secondary to eye trauma, bilateral, moderate stage	ICD-10-CM	Diagnosis
H40.33X3	Glaucoma secondary to eye trauma, bilateral, severe stage	ICD-10-CM	Diagnosis
H40.33X4	Glaucoma secondary to eye trauma, bilateral, indeterminate stage	ICD-10-CM	Diagnosis
H40.40X0	Glaucoma secondary to eye inflammation, unspecified eye, stage unspecified	ICD-10-CM	Diagnosis
H40.40X1	Glaucoma secondary to eye inflammation, unspecified eye, mild stage	ICD-10-CM	Diagnosis
H40.40X2	Glaucoma secondary to eye inflammation, unspecified eye, moderate stage	ICD-10-CM	Diagnosis
H40.40X3	Glaucoma secondary to eye inflammation, unspecified eye, severe stage	ICD-10-CM	Diagnosis
H40.40X4	Glaucoma secondary to eye inflammation, unspecified eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.41X0	Glaucoma secondary to eye inflammation, right eye, stage unspecified	ICD-10-CM	Diagnosis
H40.41X1	Glaucoma secondary to eye inflammation, right eye, mild stage	ICD-10-CM	Diagnosis
H40.41X2	Glaucoma secondary to eye inflammation, right eye, moderate stage	ICD-10-CM	Diagnosis
H40.41X3	Glaucoma secondary to eye inflammation, right eye, severe stage	ICD-10-CM	Diagnosis
H40.41X4	Glaucoma secondary to eye inflammation, right eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.42X0	Glaucoma secondary to eye inflammation, left eye, stage unspecified	ICD-10-CM	Diagnosis
H40.42X1	Glaucoma secondary to eye inflammation, left eye, mild stage	ICD-10-CM	Diagnosis
H40.42X2	Glaucoma secondary to eye inflammation, left eye, moderate stage	ICD-10-CM	Diagnosis
H40.42X3	Glaucoma secondary to eye inflammation, left eye, severe stage	ICD-10-CM	Diagnosis
H40.42X4	Glaucoma secondary to eye inflammation, left eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.43X0	Glaucoma secondary to eye inflammation, bilateral, stage unspecified	ICD-10-CM	Diagnosis
H40.43X1	Glaucoma secondary to eye inflammation, bilateral, mild stage	ICD-10-CM	Diagnosis
H40.43X2	Glaucoma secondary to eye inflammation, bilateral, moderate stage	ICD-10-CM	Diagnosis
H40.43X3	Glaucoma secondary to eye inflammation, bilateral, severe stage	ICD-10-CM	Diagnosis
H40.43X4	Glaucoma secondary to eye inflammation, bilateral, indeterminate stage	ICD-10-CM	Diagnosis
H40.50X0	Glaucoma secondary to other eye disorders, unspecified eye, stage unspecified	ICD-10-CM	Diagnosis
H40.50X1	Glaucoma secondary to other eye disorders, unspecified eye, mild stage	ICD-10-CM	Diagnosis
H40.50X2	Glaucoma secondary to other eye disorders, unspecified eye, moderate stage	ICD-10-CM	Diagnosis
H40.50X3	Glaucoma secondary to other eye disorders, unspecified eye, severe stage	ICD-10-CM	Diagnosis
H40.50X4	Glaucoma secondary to other eye disorders, unspecified eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.51X0	Glaucoma secondary to other eye disorders, right eye, stage unspecified	ICD-10-CM	Diagnosis
H40.51X1	Glaucoma secondary to other eye disorders, right eye, mild stage	ICD-10-CM	Diagnosis
H40.51X2	Glaucoma secondary to other eye disorders, right eye, moderate stage	ICD-10-CM	Diagnosis
H40.51X3	Glaucoma secondary to other eye disorders, right eye, severe stage	ICD-10-CM	Diagnosis
H40.51X4	Glaucoma secondary to other eye disorders, right eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.52X0	Glaucoma secondary to other eye disorders, left eye, stage unspecified	ICD-10-CM	Diagnosis
H40.52X1	Glaucoma secondary to other eye disorders, left eye, mild stage	ICD-10-CM	Diagnosis
H40.52X2	Glaucoma secondary to other eye disorders, left eye, moderate stage	ICD-10-CM	Diagnosis
H40.52X3	Glaucoma secondary to other eye disorders, left eye, severe stage	ICD-10-CM	Diagnosis
H40.52X4	Glaucoma secondary to other eye disorders, left eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.53X0	Glaucoma secondary to other eye disorders, bilateral, stage unspecified	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
H40.53X1	Glaucoma secondary to other eye disorders, bilateral, mild stage	ICD-10-CM	Diagnosis
H40.53X2	Glaucoma secondary to other eye disorders, bilateral, moderate stage	ICD-10-CM	Diagnosis
H40.53X3	Glaucoma secondary to other eye disorders, bilateral, severe stage	ICD-10-CM	Diagnosis
H40.53X4	Glaucoma secondary to other eye disorders, bilateral, indeterminate stage	ICD-10-CM	Diagnosis
H40.60X0	Glaucoma secondary to drugs, unspecified eye, stage unspecified	ICD-10-CM	Diagnosis
H40.60X1	Glaucoma secondary to drugs, unspecified eye, mild stage	ICD-10-CM	Diagnosis
H40.60X2	Glaucoma secondary to drugs, unspecified eye, moderate stage	ICD-10-CM	Diagnosis
H40.60X3	Glaucoma secondary to drugs, unspecified eye, severe stage	ICD-10-CM	Diagnosis
H40.60X4	Glaucoma secondary to drugs, unspecified eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.61X0	Glaucoma secondary to drugs, right eye, stage unspecified	ICD-10-CM	Diagnosis
H40.61X1	Glaucoma secondary to drugs, right eye, mild stage	ICD-10-CM	Diagnosis
H40.61X2	Glaucoma secondary to drugs, right eye, moderate stage	ICD-10-CM	Diagnosis
H40.61X3	Glaucoma secondary to drugs, right eye, severe stage	ICD-10-CM	Diagnosis
H40.61X4	Glaucoma secondary to drugs, right eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.62X0	Glaucoma secondary to drugs, left eye, stage unspecified	ICD-10-CM	Diagnosis
H40.62X1	Glaucoma secondary to drugs, left eye, mild stage	ICD-10-CM	Diagnosis
H40.62X2	Glaucoma secondary to drugs, left eye, moderate stage	ICD-10-CM	Diagnosis
H40.62X3	Glaucoma secondary to drugs, left eye, severe stage	ICD-10-CM	Diagnosis
H40.62X4	Glaucoma secondary to drugs, left eye, indeterminate stage	ICD-10-CM	Diagnosis
H40.63X0	Glaucoma secondary to drugs, bilateral, stage unspecified	ICD-10-CM	Diagnosis
H40.63X1	Glaucoma secondary to drugs, bilateral, mild stage	ICD-10-CM	Diagnosis
H40.63X2	Glaucoma secondary to drugs, bilateral, moderate stage	ICD-10-CM	Diagnosis
H40.63X3	Glaucoma secondary to drugs, bilateral, severe stage	ICD-10-CM	Diagnosis
H40.63X4	Glaucoma secondary to drugs, bilateral, indeterminate stage	ICD-10-CM	Diagnosis
H40.811	Glaucoma with increased episcleral venous pressure, right eye	ICD-10-CM	Diagnosis
H40.812	Glaucoma with increased episcleral venous pressure, left eye	ICD-10-CM	Diagnosis
H40.813	Glaucoma with increased episcleral venous pressure, bilateral	ICD-10-CM	Diagnosis
H40.819	Glaucoma with increased episcleral venous pressure, unspecified eye	ICD-10-CM	Diagnosis
H40.821	Hypersecretion glaucoma, right eye	ICD-10-CM	Diagnosis
H40.822	Hypersecretion glaucoma, left eye	ICD-10-CM	Diagnosis
H40.823	Hypersecretion glaucoma, bilateral	ICD-10-CM	Diagnosis
H40.829	Hypersecretion glaucoma, unspecified eye	ICD-10-CM	Diagnosis
H40.831	Aqueous misdirection, right eye	ICD-10-CM	Diagnosis
H40.832	Aqueous misdirection, left eye	ICD-10-CM	Diagnosis
H40.833	Aqueous misdirection, bilateral	ICD-10-CM	Diagnosis
H40.839	Aqueous misdirection, unspecified eye	ICD-10-CM	Diagnosis
H40.89	Other specified glaucoma	ICD-10-CM	Diagnosis
H40.9	Unspecified glaucoma	ICD-10-CM	Diagnosis
H42	Glaucoma in diseases classified elsewhere	ICD-10-CM	Diagnosis
H44.511	Absolute glaucoma, right eye	ICD-10-CM	Diagnosis
H44.512	Absolute glaucoma, left eye	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
H44.513	Absolute glaucoma, bilateral	ICD-10-CM	Diagnosis
H44.519	Absolute glaucoma, unspecified eye	ICD-10-CM	Diagnosis
H47.231	Glaucomatous optic atrophy, right eye	ICD-10-CM	Diagnosis
H47.232	Glaucomatous optic atrophy, left eye	ICD-10-CM	Diagnosis
H47.233	Glaucomatous optic atrophy, bilateral	ICD-10-CM	Diagnosis
H47.239	Glaucomatous optic atrophy, unspecified eye	ICD-10-CM	Diagnosis
Q15.0	Congenital glaucoma	ICD-10-CM	Diagnosis
	Heart Failure		
398.91	Rheumatic heart failure (congestive)	ICD-9-CM	Diagnosis
402.01	Malignant hypertensive heart disease with heart failure	ICD-9-CM	Diagnosis
402.11	Benign hypertensive heart disease with heart failure	ICD-9-CM	Diagnosis
402.91	Hypertensive heart disease, unspecified, with heart failure	ICD-9-CM	Diagnosis
404.01	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.11	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.91	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
428.0	Congestive heart failure, unspecified	ICD-9-CM	Diagnosis
428.1	Left heart failure	ICD-9-CM	Diagnosis
428.20	Unspecified systolic heart failure	ICD-9-CM	Diagnosis
428.21	Acute systolic heart failure	ICD-9-CM	Diagnosis
428.22	Chronic systolic heart failure	ICD-9-CM	Diagnosis
428.23	Acute on chronic systolic heart failure	ICD-9-CM	Diagnosis
428.30	Unspecified diastolic heart failure	ICD-9-CM	Diagnosis
428.31	Acute diastolic heart failure	ICD-9-CM	Diagnosis
428.32	Chronic diastolic heart failure	ICD-9-CM	Diagnosis
428.33	Acute on chronic diastolic heart failure	ICD-9-CM	Diagnosis
428.40	Unspecified combined systolic and diastolic heart failure	ICD-9-CM	Diagnosis
428.41	Acute combined systolic and diastolic heart failure	ICD-9-CM	Diagnosis
428.42	Chronic combined systolic and diastolic heart failure	ICD-9-CM	Diagnosis
428.43	Acute on chronic combined systolic and diastolic heart failure	ICD-9-CM	Diagnosis
428.9	Unspecified heart failure	ICD-9-CM	Diagnosis
I09.81	Rheumatic heart failure	ICD-10-CM	Diagnosis
I11.0	Hypertensive heart disease with heart failure	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	ICD-10-CM	Diagnosis
I50.1	Left ventricular failure, unspecified	ICD-10-CM	Diagnosis
I50.20	Unspecified systolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.21	Acute systolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.22	Chronic systolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.23	Acute on chronic systolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.30	Unspecified diastolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.31	Acute diastolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.32	Chronic diastolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.33	Acute on chronic diastolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure	ICD-10-CM	Diagnosis
I50.810	Right heart failure, unspecified	ICD-10-CM	Diagnosis
I50.811	Acute right heart failure	ICD-10-CM	Diagnosis
I50.812	Chronic right heart failure	ICD-10-CM	Diagnosis
I50.813	Acute on chronic right heart failure	ICD-10-CM	Diagnosis
I50.814	Right heart failure due to left heart failure	ICD-10-CM	Diagnosis
I50.82	Biventricular heart failure	ICD-10-CM	Diagnosis
I50.83	High output heart failure	ICD-10-CM	Diagnosis
I50.84	End stage heart failure	ICD-10-CM	Diagnosis
I50.89	Other heart failure	ICD-10-CM	Diagnosis
I50.9	Heart failure, unspecified	ICD-10-CM	Diagnosis
	Hip/Pelvic Fracture		
820.00	Closed fracture of unspecified intracapsular section of neck of femur	ICD-9-CM	Diagnosis
820.20	Closed fracture of unspecified trochanteric section of femur	ICD-9-CM	Diagnosis
820.21	Closed fracture of intertrochanteric section of femur	ICD-9-CM	Diagnosis
808.0	Closed fracture of acetabulum	ICD-9-CM	Diagnosis
820.03	Closed fracture of base of neck of femur	ICD-9-CM	Diagnosis
820.01	Closed fracture of epiphysis (separation) (upper) of neck of femur	ICD-9-CM	Diagnosis
808.41	Closed fracture of ilium	ICD-9-CM	Diagnosis
808.42	Closed fracture of ischium	ICD-9-CM	Diagnosis
820.02	Closed fracture of midcervical section of femur	ICD-9-CM	Diagnosis
808.2	Closed fracture of pubis	ICD-9-CM	Diagnosis
808.49	Closed fracture of other specified part of pelvis	ICD-9-CM	Diagnosis
820.22	Closed fracture of subtrochanteric section of femur	ICD-9-CM	Diagnosis
820.8	Closed fracture of unspecified part of neck of femur	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
808.43	Multiple closed pelvic fractures with disruption of pelvic circle	ICD-9-CM	Diagnosis
808.53	Multiple open pelvic fractures with disruption of pelvic circle	ICD-9-CM	Diagnosis
808.44	Multiple closed pelvic fractures without disruption of pelvic circle	ICD-9-CM	Diagnosis
808.54	Multiple open pelvic fractures without disruption of pelvic circle	ICD-9-CM	Diagnosis
820.31	Open fracture of intertrochanteric section of femur	ICD-9-CM	Diagnosis
808.1	Open fracture of acetabulum	ICD-9-CM	Diagnosis
820.13	Open fracture of base of neck of femur	ICD-9-CM	Diagnosis
820.11	Open fracture of epiphysis (separation) (upper) of neck of femur	ICD-9-CM	Diagnosis
808.51	Open fracture of ilium	ICD-9-CM	Diagnosis
808.52	Open fracture of ischium	ICD-9-CM	Diagnosis
820.12	Open fracture of midcervical section of femur	ICD-9-CM	Diagnosis
808.3	Open fracture of pubis	ICD-9-CM	Diagnosis
808.59	Open fracture of other specified part of pelvis	ICD-9-CM	Diagnosis
820.32	Open fracture of subtrochanteric section of femur	ICD-9-CM	Diagnosis
820.10	Open fracture of unspecified intracapsular section of neck of femur	ICD-9-CM	Diagnosis
820.30	Open fracture of unspecified trochanteric section of femur	ICD-9-CM	Diagnosis
820.9	Open fracture of unspecified part of neck of femur	ICD-9-CM	Diagnosis
820.09	Other closed transcervical fracture of femur	ICD-9-CM	Diagnosis
820.19	Other open transcervical fracture of femur	ICD-9-CM	Diagnosis
733.14	Pathologic fracture of neck of femur	ICD-9-CM	Diagnosis
733.15	Pathologic fracture of other specified part of femur	ICD-9-CM	Diagnosis
733.96	Stress fracture of femoral neck	ICD-9-CM	Diagnosis
733.98	Stress fracture of pelvis	ICD-9-CM	Diagnosis
733.97	Stress fracture of shaft of femur	ICD-9-CM	Diagnosis
808.8	Unspecified closed fracture of pelvis	ICD-9-CM	Diagnosis
808.9	Unspecified open fracture of pelvis	ICD-9-CM	Diagnosis
M80.059A	Age-related osteoporosis with current pathological fracture, unspecified femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M80.052A	Age-related osteoporosis with current pathological fracture, left femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M80.051A	Age-related osteoporosis with current pathological fracture, right femur, initial encounter for fracture	ICD-10-CM	Diagnosis
S72.042C	Displaced fracture of base of neck of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.042B	Displaced fracture of base of neck of left femur, initial encounter for open fracture type I	ICD-10-CM	Diagnosis
S72.042A	Displaced fracture of base of neck of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.041C	Displaced fracture of base of neck of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.041B	Displaced fracture of base of neck of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.041A	Displaced fracture of base of neck of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.043C	Displaced fracture of base of neck of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.043B	Displaced fracture of base of neck of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.043A	Displaced fracture of base of neck of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.022B	Displaced fracture of epiphysis (separation) (upper) of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.022C	Displaced fracture of epiphysis (separation) (upper) of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.021B	Displaced fracture of epiphysis (separation) (upper) of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.021C	Displaced fracture of epiphysis (separation) (upper) of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.023B	Displaced fracture of epiphysis (separation) (upper) of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.023C	Displaced fracture of epiphysis (separation) (upper) of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.032B	Displaced midcervical fracture of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.032C	Displaced midcervical fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.031B	Displaced midcervical fracture of right femur, initial encounter for open fracture type I	ICD-10-CM	Diagnosis
S72.031C	Displaced midcervical fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.033B	Displaced midcervical fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.033C	Displaced midcervical fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S32.433A	Displaced fracture of anterior column [iliopubic] of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.433B	Displaced fracture of anterior column [iliopubic] of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.442A	Displaced fracture of posterior column [ilioischial] of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.442B	Displaced fracture of posterior column [ilioischial] of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.432A	Displaced fracture of anterior column [iliopubic] of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.432B	Displaced fracture of anterior column [iliopubic] of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S32.431A	Displaced fracture of anterior column [iliopubic] of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.431B	Displaced fracture of anterior column [iliopubic] of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.423A	Displaced fracture of posterior wall of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.423B	Displaced fracture of posterior wall of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.312A	Displaced avulsion fracture of left ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.312B	Displaced avulsion fracture of left ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.612A	Displaced avulsion fracture of left ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.612B	Displaced avulsion fracture of left ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.311A	Displaced avulsion fracture of right ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.311B	Displaced avulsion fracture of right ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.611A	Displaced avulsion fracture of right ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.611B	Displaced avulsion fracture of right ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.313A	Displaced avulsion fracture of unspecified ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.313B	Displaced avulsion fracture of unspecified ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.613A	Displaced avulsion fracture of unspecified ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.613B	Displaced avulsion fracture of unspecified ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.482A	Displaced dome fracture of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.482B	Displaced dome fracture of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.481A	Displaced dome fracture of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.481B	Displaced dome fracture of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.483A	Displaced dome fracture of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.483B	Displaced dome fracture of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S72.022A	Displaced fracture of epiphysis (separation) (upper) of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.021A	Displaced fracture of epiphysis (separation) (upper) of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.023A	Displaced fracture of epiphysis (separation) (upper) of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.422A	Displaced fracture of posterior wall of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.422B	Displaced fracture of posterior wall of left acetabulum, initial encounter for open	ICD-10-CM	Diagnosis
S32.421A	Displaced fracture of posterior wall of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S32.421B	Displaced fracture of posterior wall of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S72.032A	Displaced midcervical fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.031A	Displaced midcervical fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.033A	Displaced midcervical fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.452A	Displaced transverse fracture of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.452B	Displaced transverse fracture of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.451A	Displaced transverse fracture of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.451B	Displaced transverse fracture of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.453A	Displaced transverse fracture of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.453B	Displaced transverse fracture of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.412B	Displaced fracture of anterior wall of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.411B	Displaced fracture of anterior wall of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.441B	Displaced fracture of posterior column [ilioischial] of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.441A	Displaced fracture of posterior column [ilioischial] of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.443A	Displaced fracture of posterior column [ilioischial] of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.443B	Displaced fracture of posterior column [ilioischial] of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.472B	Displaced fracture of medial wall of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.472A	Displaced fracture of medial wall of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.471A	Displaced fracture of medial wall of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.471B	Displaced fracture of medial wall of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.473A	Displaced fracture of medial wall of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.473B	Displaced fracture of medial wall of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.462A	Displaced associated transverse-posterior fracture of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.462B	Displaced associated transverse-posterior fracture of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.461A	Displaced associated transverse-posterior fracture of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S32.461B	Displaced associated transverse-posterior fracture of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.463A	Displaced associated transverse-posterior fracture of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.463B	Displaced associated transverse-posterior fracture of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S72.132C	Displaced apophyseal fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.132B	Displaced apophyseal fracture of left femur, initial encounter for open fracture type I or	ICD-10-CM	Diagnosis
S72.132A	Displaced apophyseal fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.131A	Displaced apophyseal fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.131B	Displaced apophyseal fracture of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.131C	Displaced apophyseal fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.133A	Displaced apophyseal fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.133B	Displaced apophyseal fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.133C	Displaced apophyseal fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.062A	Displaced articular fracture of head of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.062B	Displaced articular fracture of head of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.062C	Displaced articular fracture of head of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.061A	Displaced articular fracture of head of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.061B	Displaced articular fracture of head of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.061C	Displaced articular fracture of head of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.063B	Displaced articular fracture of head of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.063C	Displaced articular fracture of head of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.063A	Displaced articular fracture of head of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.112C	Displaced fracture of greater trochanter of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.111C	Displaced fracture of greater trochanter of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.113C	Displaced fracture of greater trochanter of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.112A	Displaced fracture of greater trochanter of left femur, initial encounter for closed	ICD-10-CM	Diagnosis
S72.112B	Displaced fracture of greater trochanter of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.111A	Displaced fracture of greater trochanter of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.111B	Displaced fracture of greater trochanter of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.113A	Displaced fracture of greater trochanter of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.113B	Displaced fracture of greater trochanter of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.122C	Displaced fracture of lesser trochanter of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.121C	Displaced fracture of lesser trochanter of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.123B	Displaced fracture of lesser trochanter of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.123C	Displaced fracture of lesser trochanter of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.122A	Displaced fracture of lesser trochanter of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.122B	Displaced fracture of lesser trochanter of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.121A	Displaced fracture of lesser trochanter of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.121B	Displaced fracture of lesser trochanter of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.123A	Displaced fracture of lesser trochanter of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.142A	Displaced intertrochanteric fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.141A	Displaced intertrochanteric fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.141C	Displaced intertrochanteric fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.141B	Displaced intertrochanteric fracture of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.22XA	Displaced subtrochanteric fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.22XB	Displaced subtrochanteric fracture of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.21XA	Displaced subtrochanteric fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.21XB	Displaced subtrochanteric fracture of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.23XA	Displaced subtrochanteric fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.412A	Displaced fracture of anterior wall of left acetabulum, initial encounter for closed	ICD-10-CM	Diagnosis
S32.411A	Displaced fracture of anterior wall of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.413A	Displaced fracture of anterior wall of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.413B	Displaced fracture of anterior wall of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S72.142C	Displaced intertrochanteric fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.142B	Displaced intertrochanteric fracture of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.143C	Displaced intertrochanteric fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.143A	Displaced intertrochanteric fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.143B	Displaced intertrochanteric fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.22XC	Displaced subtrochanteric fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.21XC	Displaced subtrochanteric fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.23XC	Displaced subtrochanteric fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.23XB	Displaced subtrochanteric fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S32.89XA	Fracture of other parts of pelvis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.89XB	Fracture of other parts of pelvis, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.512A	Fracture of superior rim of left pubis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.512B	Fracture of superior rim of left pubis, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.511A	Fracture of superior rim of right pubis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.511B	Fracture of superior rim of right pubis, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.519A	Fracture of superior rim of unspecified pubis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.519B	Fracture of superior rim of unspecified pubis, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.9XXA	Fracture of unspecified parts of lumbosacral spine and pelvis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.9XXB	Fracture of unspecified parts of lumbosacral spine and pelvis, initial encounter for open fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.002C	Fracture of unspecified part of neck of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.002B	Fracture of unspecified part of neck of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.002A	Fracture of unspecified part of neck of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.001C	Fracture of unspecified part of neck of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.001B	Fracture of unspecified part of neck of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.001A	Fracture of unspecified part of neck of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.009B	Fracture of unspecified part of neck of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.009C	Fracture of unspecified part of neck of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.009A	Fracture of unspecified part of neck of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.810B	Multiple fractures of pelvis with stable disruption of pelvic ring, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.811A	Multiple fractures of pelvis with unstable disruption of pelvic ring, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.82XA	Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.82XB	Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.810A	Multiple fractures of pelvis with stable disruption of pelvic ring, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.811B	Multiple fractures of pelvis with unstable disruption of pelvic ring, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.446A	Nondisplaced fracture of posterior column [ilioischial] of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.446B	Nondisplaced fracture of posterior column [ilioischial] of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S72.135A	Nondisplaced apophyseal fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.135B	Nondisplaced apophyseal fracture of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.135C	Nondisplaced apophyseal fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.134B	Nondisplaced apophyseal fracture of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.134C	Nondisplaced apophyseal fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.134A	Nondisplaced apophyseal fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.136B	Nondisplaced apophyseal fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.136C	Nondisplaced apophyseal fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.136A	Nondisplaced apophyseal fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.065C	Nondisplaced articular fracture of head of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.064C	Nondisplaced articular fracture of head of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.066C	Nondisplaced articular fracture of head of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.065A	Nondisplaced articular fracture of head of left femur, initial encounter for closed	ICD-10-CM	Diagnosis
S72.065B	Nondisplaced articular fracture of head of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.064A	Nondisplaced articular fracture of head of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.064B	Nondisplaced articular fracture of head of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.066A	Nondisplaced articular fracture of head of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.066B	Nondisplaced articular fracture of head of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.115C	Nondisplaced fracture of greater trochanter of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.114C	Nondisplaced fracture of greater trochanter of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.116B	Nondisplaced fracture of greater trochanter of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.116C	Nondisplaced fracture of greater trochanter of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.115A	Nondisplaced fracture of greater trochanter of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.115B	Nondisplaced fracture of greater trochanter of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.114B	Nondisplaced fracture of greater trochanter of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.114A	Nondisplaced fracture of greater trochanter of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.116A	Nondisplaced fracture of greater trochanter of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.125A	Nondisplaced fracture of lesser trochanter of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.125B	Nondisplaced fracture of lesser trochanter of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.125C	Nondisplaced fracture of lesser trochanter of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.124A	Nondisplaced fracture of lesser trochanter of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.124B	Nondisplaced fracture of lesser trochanter of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.124C	Nondisplaced fracture of lesser trochanter of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.126A	Nondisplaced fracture of lesser trochanter of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.126B	Nondisplaced fracture of lesser trochanter of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.126C	Nondisplaced fracture of lesser trochanter of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.145A	Nondisplaced intertrochanteric fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.144A	Nondisplaced intertrochanteric fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.145C	Nondisplaced intertrochanteric fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.145B	Nondisplaced intertrochanteric fracture of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.144C	Nondisplaced intertrochanteric fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.144B	Nondisplaced intertrochanteric fracture of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.146B	Nondisplaced intertrochanteric fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.146A	Nondisplaced intertrochanteric fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.146C	Nondisplaced intertrochanteric fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.24XC	Nondisplaced subtrochanteric fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.25XB	Nondisplaced subtrochanteric fracture of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.25XC	Nondisplaced subtrochanteric fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.24XA	Nondisplaced subtrochanteric fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.24XB	Nondisplaced subtrochanteric fracture of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.26XA	Nondisplaced subtrochanteric fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.26XB	Nondisplaced subtrochanteric fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.26XC	Nondisplaced subtrochanteric fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S32.414B	Nondisplaced fracture of anterior wall of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.414A	Nondisplaced fracture of anterior wall of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.416A	Nondisplaced fracture of anterior wall of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.426A	Nondisplaced fracture of posterior wall of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.415A	Nondisplaced fracture of anterior wall of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.415B	Nondisplaced fracture of anterior wall of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.315A	Nondisplaced avulsion fracture of left ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.316A	Nondisplaced avulsion fracture of unspecified ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.315B	Nondisplaced avulsion fracture of left ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.314A	Nondisplaced avulsion fracture of right ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.314B	Nondisplaced avulsion fracture of right ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.316B	Nondisplaced avulsion fracture of unspecified ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.615A	Nondisplaced avulsion fracture of left ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.614A	Nondisplaced avulsion fracture of right ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.614B	Nondisplaced avulsion fracture of right ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.616A	Nondisplaced avulsion fracture of unspecified ischium, initial encounter for closed	ICD-10-CM	Diagnosis
S32.616B	Nondisplaced avulsion fracture of unspecified ischium, initial encounter for open	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S32.486A	Nondisplaced dome fracture of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.486B	Nondisplaced dome fracture of unspecified acetabulum, initial encounter for open	ICD-10-CM	Diagnosis
S32.416B	Nondisplaced fracture of anterior wall of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.425A	Nondisplaced fracture of posterior wall of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.425B	Nondisplaced fracture of posterior wall of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.424A	Nondisplaced fracture of posterior wall of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.424B	Nondisplaced fracture of posterior wall of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.485A	Nondisplaced dome fracture of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.485B	Nondisplaced dome fracture of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.484A	Nondisplaced dome fracture of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.484B	Nondisplaced dome fracture of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.436B	Nondisplaced fracture of anterior column [iliopubic] of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.435B	Nondisplaced fracture of anterior column [iliopubic] of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.435A	Nondisplaced fracture of anterior column [iliopubic] of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.434A	Nondisplaced fracture of anterior column [iliopubic] of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.434B	Nondisplaced fracture of anterior column [iliopubic] of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.436A	Nondisplaced fracture of anterior column [iliopubic] of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.045A	Nondisplaced fracture of base of neck of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.045B	Nondisplaced fracture of base of neck of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.045C	Nondisplaced fracture of base of neck of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.044A	Nondisplaced fracture of base of neck of right femur, initial encounter for closed	ICD-10-CM	Diagnosis
S72.044B	Nondisplaced fracture of base of neck of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.044C	Nondisplaced fracture of base of neck of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.046A	Nondisplaced fracture of base of neck of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.046B	Nondisplaced fracture of base of neck of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.046C	Nondisplaced fracture of base of neck of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.025A	Nondisplaced fracture of epiphysis (separation) (upper) of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.025B	Nondisplaced fracture of epiphysis (separation) (upper) of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.025C	Nondisplaced fracture of epiphysis (separation) (upper) of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.024A	Nondisplaced fracture of epiphysis (separation) (upper) of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.024B	Nondisplaced fracture of epiphysis (separation) (upper) of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.024C	Nondisplaced fracture of epiphysis (separation) (upper) of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.026A	Nondisplaced fracture of epiphysis (separation) (upper) of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.026B	Nondisplaced fracture of epiphysis (separation) (upper) of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.026C	Nondisplaced fracture of epiphysis (separation) (upper) of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S32.445A	Nondisplaced fracture of posterior column [ilioischial] of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.445B	Nondisplaced fracture of posterior column [ilioischial] of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.444B	Nondisplaced fracture of posterior column [ilioischial] of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.444A	Nondisplaced fracture of posterior column [ilioischial] of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.035B	Nondisplaced midcervical fracture of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.035C	Nondisplaced midcervical fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.035A	Nondisplaced midcervical fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.034B	Nondisplaced midcervical fracture of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.034C	Nondisplaced midcervical fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.034A	Nondisplaced midcervical fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.036B	Nondisplaced midcervical fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.036C	Nondisplaced midcervical fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.036A	Nondisplaced midcervical fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.615B	Nondisplaced avulsion fracture of left ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.426B	Nondisplaced fracture of posterior wall of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.465A	Nondisplaced associated transverse-posterior fracture of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.465B	Nondisplaced associated transverse-posterior fracture of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.464A	Nondisplaced associated transverse-posterior fracture of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.464B	Nondisplaced associated transverse-posterior fracture of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.475A	Nondisplaced fracture of medial wall of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.475B	Nondisplaced fracture of medial wall of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.474A	Nondisplaced fracture of medial wall of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.474B	Nondisplaced fracture of medial wall of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.476A	Nondisplaced fracture of medial wall of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.476B	Nondisplaced fracture of medial wall of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S72.25XA	Nondisplaced subtrochanteric fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.466A	Nondisplaced associated transverse-posterior fracture of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.466B	Nondisplaced associated transverse-posterior fracture of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.455A	Nondisplaced transverse fracture of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.455B	Nondisplaced transverse fracture of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.454A	Nondisplaced transverse fracture of right acetabulum, initial encounter for closed	ICD-10-CM	Diagnosis
S32.454B	Nondisplaced transverse fracture of right acetabulum, initial encounter for open	ICD-10-CM	Diagnosis

Code	Description	Code Type	Code Category
S32.456A	Nondisplaced transverse fracture of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.456B	Nondisplaced transverse fracture of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S72.092B	Other fracture of head and neck of left femur, initial encounter for open fracture type I	ICD-10-CM	Diagnosis
S72.092C	Other fracture of head and neck of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.092A	Other fracture of head and neck of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.091B	Other fracture of head and neck of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.091C	Other fracture of head and neck of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.091A	Other fracture of head and neck of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.099B	Other fracture of head and neck of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.099C	Other fracture of head and neck of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.099A	Other fracture of head and neck of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
M80.852A	Other osteoporosis with current pathological fracture, left femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M80.851A	Other osteoporosis with current pathological fracture, right femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M80.859A	Other osteoporosis with current pathological fracture, unspecified femur, initial encounter for fracture	ICD-10-CM	Diagnosis
S79.092A	Other physeal fracture of upper end of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S79.091A	Other physeal fracture of upper end of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S79.099A	Other physeal fracture of upper end of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.392B	Other fracture of left ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.392A	Other fracture of left ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.391A	Other fracture of right ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.391B	Other fracture of right ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.399A	Other fracture of unspecified ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.399B	Other fracture of unspecified ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.492A	Other specified fracture of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.492B	Other specified fracture of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.692A	Other specified fracture of left ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.692B	Other specified fracture of left ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.491A	Other specified fracture of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.491B	Other specified fracture of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S32.691A	Other specified fracture of right ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.691B	Other specified fracture of right ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.499A	Other specified fracture of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.499B	Other specified fracture of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.699A	Other specified fracture of unspecified ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.699B	Other specified fracture of unspecified ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.592A	Other specified fracture of left pubis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.592B	Other specified fracture of left pubis, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.591A	Other specified fracture of right pubis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.591B	Other specified fracture of right pubis, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.599A	Other specified fracture of unspecified pubis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.599B	Other specified fracture of unspecified pubis, initial encounter for open fracture	ICD-10-CM	Diagnosis
M84.559A	Pathological fracture in neoplastic disease, hip, unspecified, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.553A	Pathological fracture in neoplastic disease, unspecified femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.459A	Pathological fracture, hip, unspecified, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.452A	Pathological fracture, left femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.552A	Pathological fracture in neoplastic disease, left femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.550A	Pathological fracture in neoplastic disease, pelvis, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.551A	Pathological fracture in neoplastic disease, right femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.650A	Pathological fracture in other disease, pelvis, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.659A	Pathological fracture in other disease, hip, unspecified, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.652A	Pathological fracture in other disease, left femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.651A	Pathological fracture in other disease, right femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.653A	Pathological fracture in other disease, unspecified femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.451A	Pathological fracture, right femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.453A	Pathological fracture, unspecified femur, initial encounter for fracture	ICD-10-CM	Diagnosis
S79.012A	Salter-Harris Type I physeal fracture of upper end of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S79.011A	Salter-Harris Type I physeal fracture of upper end of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S79.019A	Salter-Harris Type I physeal fracture of upper end of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
M84.359A	Stress fracture, hip, unspecified, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.352A	Stress fracture, left femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.350A	Stress fracture, pelvis, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.351A	Stress fracture, right femur, initial encounter for fracture	ICD-10-CM	Diagnosis
M84.353A	Stress fracture, unspecified femur, initial encounter for fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S72.052A	Unspecified fracture of head of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.051A	Unspecified fracture of head of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.402A	Unspecified fracture of left acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.052B	Unspecified fracture of head of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.052C	Unspecified fracture of head of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.051B	Unspecified fracture of head of right femur, initial encounter for open fracture type I or	ICD-10-CM	Diagnosis
S72.051C	Unspecified fracture of head of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.059B	Unspecified fracture of head of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.059C	Unspecified fracture of head of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.059A	Unspecified fracture of head of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.012A	Unspecified intracapsular fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.012B	Unspecified intracapsular fracture of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.012C	Unspecified intracapsular fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.011A	Unspecified intracapsular fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.011B	Unspecified intracapsular fracture of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.011C	Unspecified intracapsular fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.019A	Unspecified intracapsular fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.019B	Unspecified intracapsular fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.019C	Unspecified intracapsular fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S79.002A	Unspecified physeal fracture of upper end of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S79.001A	Unspecified physeal fracture of upper end of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S79.009A	Unspecified physeal fracture of upper end of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.102B	Unspecified trochanteric fracture of left femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.102C	Unspecified trochanteric fracture of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis

Code	Description	Code Type	Code Category
S72.101B	Unspecified trochanteric fracture of right femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.101C	Unspecified trochanteric fracture of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.109B	Unspecified trochanteric fracture of unspecified femur, initial encounter for open fracture type I or II	ICD-10-CM	Diagnosis
S72.109C	Unspecified trochanteric fracture of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	ICD-10-CM	Diagnosis
S72.102A	Unspecified trochanteric fracture of left femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.101A	Unspecified trochanteric fracture of right femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S72.109A	Unspecified trochanteric fracture of unspecified femur, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.402B	Unspecified fracture of left acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.401A	Unspecified fracture of right acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.401B	Unspecified fracture of right acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.409A	Unspecified fracture of unspecified acetabulum, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.409B	Unspecified fracture of unspecified acetabulum, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.309A	Unspecified fracture of unspecified ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.302B	Unspecified fracture of left ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.302A	Unspecified fracture of left ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.602A	Unspecified fracture of left ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.602B	Unspecified fracture of left ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.502A	Unspecified fracture of left pubis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.502B	Unspecified fracture of left pubis, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.301A	Unspecified fracture of right ilium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.301B	Unspecified fracture of right ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.601A	Unspecified fracture of right ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.601B	Unspecified fracture of right ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.501A	Unspecified fracture of right pubis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.501B	Unspecified fracture of right pubis, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.309B	Unspecified fracture of unspecified ilium, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.509A	Unspecified fracture of unspecified pubis, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.509B	Unspecified fracture of unspecified pubis, initial encounter for open fracture	ICD-10-CM	Diagnosis
S32.609A	Unspecified fracture of unspecified ischium, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S32.609B	Unspecified fracture of unspecified ischium, initial encounter for open fracture	ICD-10-CM	Diagnosis
	Hyperlipidemia		
272.0	Pure hypercholesterolemia	ICD-9-CM	Diagnosis
272.1	Pure hyperglyceridemia	ICD-9-CM	Diagnosis
272.2	Mixed hyperlipidemia	ICD-9-CM	Diagnosis
272.3	Hyperchylomicronemia	ICD-9-CM	Diagnosis
272.4	Other and unspecified hyperlipidemia	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
E78.41	Elevated Lipoprotein(a)	ICD-10-CM	Diagnosis
E78.01	Familial hypercholesterolemia	ICD-10-CM	Diagnosis
E78.3	Hyperchylomicronemia	ICD-10-CM	Diagnosis
E78.5	Hyperlipidemia, unspecified	ICD-10-CM	Diagnosis
E78.2	Mixed hyperlipidemia	ICD-10-CM	Diagnosis
E78.4	Other hyperlipidemia	ICD-10-CM	Diagnosis
E78.49	Other hyperlipidemia	ICD-10-CM	Diagnosis
E78.0	Pure hypercholesterolemia	ICD-10-CM	Diagnosis
E78.00	Pure hypercholesterolemia, unspecified	ICD-10-CM	Diagnosis
E78.1	Pure hyperglyceridemia	ICD-10-CM	Diagnosis
	Hypertension		
362.11	Hypertensive retinopathy	ICD-9-CM	Diagnosis
401.0	Essential hypertension, malignant	ICD-9-CM	Diagnosis
401.1	Essential hypertension, benign	ICD-9-CM	Diagnosis
401.9	Unspecified essential hypertension	ICD-9-CM	Diagnosis
402.00	Malignant hypertensive heart disease without heart failure	ICD-9-CM	Diagnosis
402.01	Malignant hypertensive heart disease with heart failure	ICD-9-CM	Diagnosis
402.10	Benign hypertensive heart disease without heart failure	ICD-9-CM	Diagnosis
402.11	Benign hypertensive heart disease with heart failure	ICD-9-CM	Diagnosis
402.90	Unspecified hypertensive heart disease without heart failure	ICD-9-CM	Diagnosis
402.91	Hypertensive heart disease, unspecified, with heart failure	ICD-9-CM	Diagnosis
403.00	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
403.01	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
403.10	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
403.11	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
403.90	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
403.91	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.00	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
404.01	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
404.02	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
404.10	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
404.11	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
404.12	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.90	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
404.91	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	ICD-9-CM	Diagnosis
404.92	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
405.01	Secondary renovascular hypertension, malignant	ICD-9-CM	Diagnosis
405.09	Other secondary hypertension, malignant	ICD-9-CM	Diagnosis
405.11	Secondary renovascular hypertension, benign	ICD-9-CM	Diagnosis
405.19	Other secondary hypertension, benign	ICD-9-CM	Diagnosis
405.91	Secondary renovascular hypertension, unspecified	ICD-9-CM	Diagnosis
405.99	Other secondary hypertension, unspecified	ICD-9-CM	Diagnosis
437.2	Hypertensive encephalopathy	ICD-9-CM	Diagnosis
H35.031	Hypertensive retinopathy, right eye	ICD-10-CM	Diagnosis
H35.032	Hypertensive retinopathy, left eye	ICD-10-CM	Diagnosis
H35.033	Hypertensive retinopathy, bilateral	ICD-10-CM	Diagnosis
H35.039	Hypertensive retinopathy, unspecified eye	ICD-10-CM	Diagnosis
I10	Essential (primary) hypertension	ICD-10-CM	Diagnosis
I11.0	Hypertensive heart disease with heart failure	ICD-10-CM	Diagnosis
I11.9	Hypertensive heart disease without heart failure	ICD-10-CM	Diagnosis
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	ICD-10-CM	Diagnosis
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis
I13.10	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis
I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	ICD-10-CM	Diagnosis
I15.0	Renovascular hypertension	ICD-10-CM	Diagnosis
I15.1	Hypertension secondary to other renal disorders	ICD-10-CM	Diagnosis
I15.2	Hypertension secondary to endocrine disorders	ICD-10-CM	Diagnosis
I15.8	Other secondary hypertension	ICD-10-CM	Diagnosis
I15.9	Secondary hypertension, unspecified	ICD-10-CM	Diagnosis
I67.4	Hypertensive encephalopathy	ICD-10-CM	Diagnosis
N26.2	Page kidney	ICD-10-CM	Diagnosis
	Ischemic Heart Disease		
410.00	Acute myocardial infarction of anterolateral wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.01	Acute myocardial infarction of anterolateral wall, initial episode of care	ICD-9-CM	Diagnosis
410.02	Acute myocardial infarction of anterolateral wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.10	Acute myocardial infarction of other anterior wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.11	Acute myocardial infarction of other anterior wall, initial episode of care	ICD-9-CM	Diagnosis
410.12	Acute myocardial infarction of other anterior wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.20	Acute myocardial infarction of inferolateral wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.21	Acute myocardial infarction of inferolateral wall, initial episode of care	ICD-9-CM	Diagnosis
410.22	Acute myocardial infarction of inferolateral wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.30	Acute myocardial infarction of inferoposterior wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.31	Acute myocardial infarction of inferoposterior wall, initial episode of care	ICD-9-CM	Diagnosis
410.32	Acute myocardial infarction of inferoposterior wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.40	Acute myocardial infarction of other inferior wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.41	Acute myocardial infarction of other inferior wall, initial episode of care	ICD-9-CM	Diagnosis
410.42	Acute myocardial infarction of other inferior wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.50	Acute myocardial infarction of other lateral wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.51	Acute myocardial infarction of other lateral wall, initial episode of care	ICD-9-CM	Diagnosis
410.52	Acute myocardial infarction of other lateral wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.60	Acute myocardial infarction, true posterior wall infarction, episode of care unspecified	ICD-9-CM	Diagnosis
410.61	Acute myocardial infarction, true posterior wall infarction, initial episode of care	ICD-9-CM	Diagnosis
410.62	Acute myocardial infarction, true posterior wall infarction, subsequent episode of care	ICD-9-CM	Diagnosis
410.70	Acute myocardial infarction, subendocardial infarction, episode of care unspecified	ICD-9-CM	Diagnosis
410.71	Acute myocardial infarction, subendocardial infarction, initial episode of care	ICD-9-CM	Diagnosis
410.72	Acute myocardial infarction, subendocardial infarction, subsequent episode of care	ICD-9-CM	Diagnosis
410.80	Acute myocardial infarction of other specified sites, episode of care unspecified	ICD-9-CM	Diagnosis
410.81	Acute myocardial infarction of other specified sites, initial episode of care	ICD-9-CM	Diagnosis
410.82	Acute myocardial infarction of other specified sites, subsequent episode of care	ICD-9-CM	Diagnosis
410.90	Acute myocardial infarction, unspecified site, episode of care unspecified	ICD-9-CM	Diagnosis
410.91	Acute myocardial infarction, unspecified site, initial episode of care	ICD-9-CM	Diagnosis
410.92	Acute myocardial infarction, unspecified site, subsequent episode of care	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
411.0	Postmyocardial infarction syndrome	ICD-9-CM	Diagnosis
411.1	Intermediate coronary syndrome	ICD-9-CM	Diagnosis
411.81	Acute coronary occlusion without myocardial infarction	ICD-9-CM	Diagnosis
411.89	Other acute and subacute form of ischemic heart disease	ICD-9-CM	Diagnosis
412	Old myocardial infarction	ICD-9-CM	Diagnosis
413.0	Angina decubitus	ICD-9-CM	Diagnosis
413.1	Prinzmetal angina	ICD-9-CM	Diagnosis
413.9	Other and unspecified angina pectoris	ICD-9-CM	Diagnosis
414.00	Coronary atherosclerosis of unspecified type of vessel, native or graft	ICD-9-CM	Diagnosis
414.01	Coronary atherosclerosis of native coronary artery	ICD-9-CM	Diagnosis
414.02	Coronary atherosclerosis of autologous vein bypass graft	ICD-9-CM	Diagnosis
414.03	Coronary atherosclerosis of nonautologous biological bypass graft	ICD-9-CM	Diagnosis
414.04	Coronary atherosclerosis of artery bypass graft	ICD-9-CM	Diagnosis
414.05	Coronary atherosclerosis of unspecified type of bypass graft	ICD-9-CM	Diagnosis
414.06	Coronary atherosclerosis, of native coronary artery of transplanted heart	ICD-9-CM	Diagnosis
414.07	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart	ICD-9-CM	Diagnosis
414.12	Dissection of coronary artery	ICD-9-CM	Diagnosis
414.2	Chronic total occlusion of coronary artery	ICD-9-CM	Diagnosis
414.3	Coronary atherosclerosis due to lipid rich plaque	ICD-9-CM	Diagnosis
414.4	Coronary atherosclerosis due to calcified coronary lesion	ICD-9-CM	Diagnosis
414.8	Other specified forms of chronic ischemic heart disease	ICD-9-CM	Diagnosis
414.9	Unspecified chronic ischemic heart disease	ICD-9-CM	Diagnosis
I20.0	Unstable angina	ICD-10-CM	Diagnosis
I20.1	Angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I20.8	Other forms of angina pectoris	ICD-10-CM	Diagnosis
I20.9	Angina pectoris, unspecified	ICD-10-CM	Diagnosis
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery	ICD-10-CM	Diagnosis
I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery	ICD-10-CM	Diagnosis
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall	ICD-10-CM	Diagnosis
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery	ICD-10-CM	Diagnosis
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall	ICD-10-CM	Diagnosis
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery	ICD-10-CM	Diagnosis
I21.29	ST elevation (STEMI) myocardial infarction involving other sites	ICD-10-CM	Diagnosis
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site	ICD-10-CM	Diagnosis
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	ICD-10-CM	Diagnosis
I21.A1	Myocardial infarction type 2	ICD-10-CM	Diagnosis
I21.A9	Other myocardial infarction type	ICD-10-CM	Diagnosis
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall	ICD-10-CM	Diagnosis
I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction	ICD-10-CM	Diagnosis
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites	ICD-10-CM	Diagnosis
I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site	ICD-10-CM	Diagnosis
I23.0	Hemopericardium as current complication following acute myocardial infarction	ICD-10-CM	Diagnosis
I23.1	Atrial septal defect as current complication following acute myocardial infarction	ICD-10-CM	Diagnosis
I23.2	Ventricular septal defect as current complication following acute myocardial infarction	ICD-10-CM	Diagnosis
I23.3	Rupture of cardiac wall without hemopericardium as current complication following acute myocardial infarction	ICD-10-CM	Diagnosis
I23.4	Rupture of chordae tendineae as current complication following acute myocardial infarction	ICD-10-CM	Diagnosis
I23.5	Rupture of papillary muscle as current complication following acute myocardial	ICD-10-CM	Diagnosis
I23.6	Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction	ICD-10-CM	Diagnosis
I23.7	Postinfarction angina	ICD-10-CM	Diagnosis
I23.8	Other current complications following acute myocardial infarction	ICD-10-CM	Diagnosis
I24.0	Acute coronary thrombosis not resulting in myocardial infarction	ICD-10-CM	Diagnosis
I24.1	Dressler's syndrome	ICD-10-CM	Diagnosis
I24.8	Other forms of acute ischemic heart disease	ICD-10-CM	Diagnosis
I24.9	Acute ischemic heart disease, unspecified	ICD-10-CM	Diagnosis
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris	ICD-10-CM	Diagnosis
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.111	Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina	ICD-10-CM	Diagnosis
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.2	Old myocardial infarction	ICD-10-CM	Diagnosis
I25.3	Aneurysm of heart	ICD-10-CM	Diagnosis
I25.41	Coronary artery aneurysm	ICD-10-CM	Diagnosis
I25.42	Coronary artery dissection	ICD-10-CM	Diagnosis
I25.5	Ischemic cardiomyopathy	ICD-10-CM	Diagnosis
I25.6	Silent myocardial ischemia	ICD-10-CM	Diagnosis
I25.700	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.701	Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.708	Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.709	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina	ICD-10-CM	Diagnosis
I25.710	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I25.711	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.718	Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.719	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.720	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.721	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.728	Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.729	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.730	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.731	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.738	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.739	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.750	Atherosclerosis of native coronary artery of transplanted heart with unstable angina	ICD-10-CM	Diagnosis
I25.751	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.758	Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.759	Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.760	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina	ICD-10-CM	Diagnosis
I25.761	Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.768	Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.769	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.790	Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.791	Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I25.798	Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.799	Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.810	Atherosclerosis of coronary artery bypass graft(s) without angina pectoris	ICD-10-CM	Diagnosis
I25.811	Atherosclerosis of native coronary artery of transplanted heart without angina pectoris	ICD-10-CM	Diagnosis
I25.812	Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris	ICD-10-CM	Diagnosis
I25.82	Chronic total occlusion of coronary artery	ICD-10-CM	Diagnosis
I25.83	Coronary atherosclerosis due to lipid rich plaque	ICD-10-CM	Diagnosis
I25.84	Coronary atherosclerosis due to calcified coronary lesion	ICD-10-CM	Diagnosis
I25.89	Other forms of chronic ischemic heart disease	ICD-10-CM	Diagnosis
I25.9	Chronic ischemic heart disease, unspecified	ICD-10-CM	Diagnosis
	Lung Cancer		
162.2	Malignant neoplasm of main bronchus	ICD-9-CM	Diagnosis
162.3	Malignant neoplasm of upper lobe, bronchus, or lung	ICD-9-CM	Diagnosis
162.4	Malignant neoplasm of middle lobe, bronchus, or lung	ICD-9-CM	Diagnosis
162.5	Malignant neoplasm of lower lobe, bronchus, or lung	ICD-9-CM	Diagnosis
162.8	Malignant neoplasm of other parts of bronchus or lung	ICD-9-CM	Diagnosis
162.9	Malignant neoplasm of bronchus and lung, unspecified site	ICD-9-CM	Diagnosis
231.2	Carcinoma in situ of bronchus and lung	ICD-9-CM	Diagnosis
V10.11	Personal history of malignant neoplasm of bronchus and lung	ICD-9-CM	Diagnosis
C34.00	Malignant neoplasm of unspecified main bronchus	ICD-10-CM	Diagnosis
C34.01	Malignant neoplasm of right main bronchus	ICD-10-CM	Diagnosis
C34.02	Malignant neoplasm of left main bronchus	ICD-10-CM	Diagnosis
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung	ICD-10-CM	Diagnosis
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung	ICD-10-CM	Diagnosis
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung	ICD-10-CM	Diagnosis
C34.2	Malignant neoplasm of middle lobe, bronchus or lung	ICD-10-CM	Diagnosis
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung	ICD-10-CM	Diagnosis
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung	ICD-10-CM	Diagnosis
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung	ICD-10-CM	Diagnosis
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung	ICD-10-CM	Diagnosis
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung	ICD-10-CM	Diagnosis
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung	ICD-10-CM	Diagnosis
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung	ICD-10-CM	Diagnosis
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung	ICD-10-CM	Diagnosis
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung	ICD-10-CM	Diagnosis
D02.20	Carcinoma in situ of unspecified bronchus and lung	ICD-10-CM	Diagnosis
D02.21	Carcinoma in situ of right bronchus and lung	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
D02.22	Carcinoma in situ of left bronchus and lung	ICD-10-CM	Diagnosis
Z85.110	Personal history of malignant carcinoid tumor of bronchus and lung	ICD-10-CM	Diagnosis
Z85.118	Personal history of other malignant neoplasm of bronchus and lung	ICD-10-CM	Diagnosis
	Osteoporosis		
733.00	Unspecified osteoporosis	ICD-9-CM	Diagnosis
733.01	Senile osteoporosis	ICD-9-CM	Diagnosis
733.02	Idiopathic osteoporosis	ICD-9-CM	Diagnosis
733.03	Disuse osteoporosis	ICD-9-CM	Diagnosis
733.09	Other osteoporosis	ICD-9-CM	Diagnosis
M81.0	Age-related osteoporosis without current pathological fracture	ICD-10-CM	Diagnosis
M81.6	Localized osteoporosis [Lequesne]	ICD-10-CM	Diagnosis
M81.8	Other osteoporosis without current pathological fracture	ICD-10-CM	Diagnosis
	Prostate Cancer		
185	Malignant neoplasm of prostate	ICD-9-CM	Diagnosis
233.4	Carcinoma in situ of prostate	ICD-9-CM	Diagnosis
V10.46	Personal history of malignant neoplasm of prostate	ICD-9-CM	Diagnosis
C61	Malignant neoplasm of prostate	ICD-10-CM	Diagnosis
D07.5	Carcinoma in situ of prostate	ICD-10-CM	Diagnosis
Z85.46	Personal history of malignant neoplasm of prostate	ICD-10-CM	Diagnosis
	Rheumatoid Arthritis/Osteoarthritis		
714.0	Rheumatoid arthritis	ICD-9-CM	Diagnosis
714.1	Felty's syndrome	ICD-9-CM	Diagnosis
714.2	Other rheumatoid arthritis with visceral or systemic involvement	ICD-9-CM	Diagnosis
714.30	Polyarticular juvenile rheumatoid arthritis, chronic or unspecified	ICD-9-CM	Diagnosis
714.31	Polyarticular juvenile rheumatoid arthritis, acute	ICD-9-CM	Diagnosis
714.32	Pauciarticular juvenile rheumatoid arthritis	ICD-9-CM	Diagnosis
714.33	Monoarticular juvenile rheumatoid arthritis	ICD-9-CM	Diagnosis
715.00	Generalized osteoarthrosis, unspecified site	ICD-9-CM	Diagnosis
715.04	Generalized osteoarthrosis, involving hand	ICD-9-CM	Diagnosis
715.09	Generalized osteoarthrosis, involving multiple sites	ICD-9-CM	Diagnosis
715.10	Primary localized osteoarthrosis, unspecified site	ICD-9-CM	Diagnosis
715.11	Primary localized osteoarthrosis, shoulder region	ICD-9-CM	Diagnosis
715.12	Primary localized osteoarthrosis, upper arm	ICD-9-CM	Diagnosis
715.13	Primary localized osteoarthrosis, forearm	ICD-9-CM	Diagnosis
715.14	Primary localized osteoarthrosis, hand	ICD-9-CM	Diagnosis
715.15	Primary localized osteoarthrosis, pelvic region and thigh	ICD-9-CM	Diagnosis
715.16	Primary localized osteoarthrosis, lower leg	ICD-9-CM	Diagnosis
715.17	Primary localized osteoarthrosis, ankle and foot	ICD-9-CM	Diagnosis
715.18	Primary localized osteoarthrosis, other specified sites	ICD-9-CM	Diagnosis
715.20	Secondary localized osteoarthrosis, unspecified site	ICD-9-CM	Diagnosis
715.21	Secondary localized osteoarthrosis, shoulder region	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
715.22	Secondary localized osteoarthrosis, upper arm	ICD-9-CM	Diagnosis
715.23	Secondary localized osteoarthrosis, forearm	ICD-9-CM	Diagnosis
715.24	Secondary localized osteoarthrosis, involving hand	ICD-9-CM	Diagnosis
715.25	Secondary localized osteoarthrosis, pelvic region and thigh	ICD-9-CM	Diagnosis
715.26	Secondary localized osteoarthrosis, lower leg	ICD-9-CM	Diagnosis
715.27	Secondary localized osteoarthrosis, ankle and foot	ICD-9-CM	Diagnosis
715.28	Secondary localized osteoarthrosis, other specified site	ICD-9-CM	Diagnosis
715.30	Localized osteoarthrosis not specified whether primary or secondary, unspecified site	ICD-9-CM	Diagnosis
715.31	Localized osteoarthrosis not specified whether primary or secondary, shoulder region	ICD-9-CM	Diagnosis
715.32	Localized osteoarthrosis not specified whether primary or secondary, upper arm	ICD-9-CM	Diagnosis
715.33	Localized osteoarthrosis not specified whether primary or secondary, forearm	ICD-9-CM	Diagnosis
715.34	Localized osteoarthrosis not specified whether primary or secondary, hand	ICD-9-CM	Diagnosis
715.35	Localized osteoarthrosis not specified whether primary or secondary, pelvic region and thigh	ICD-9-CM	Diagnosis
715.36	Localized osteoarthrosis not specified whether primary or secondary, lower leg	ICD-9-CM	Diagnosis
715.37	Localized osteoarthrosis not specified whether primary or secondary, ankle and foot	ICD-9-CM	Diagnosis
715.38	Localized osteoarthrosis not specified whether primary or secondary, other specified sites	ICD-9-CM	Diagnosis
715.80	Osteoarthrosis involving more than one site, but not specified as generalized, unspecified site	ICD-9-CM	Diagnosis
715.89	Osteoarthrosis involving multiple sites, but not specified as generalized	ICD-9-CM	Diagnosis
715.90	Osteoarthrosis, unspecified whether generalized or localized, unspecified site	ICD-9-CM	Diagnosis
715.91	Osteoarthrosis, unspecified whether generalized or localized, shoulder region	ICD-9-CM	Diagnosis
715.92	Osteoarthrosis, unspecified whether generalized or localized, upper arm	ICD-9-CM	Diagnosis
715.93	Osteoarthrosis, unspecified whether generalized or localized, forearm	ICD-9-CM	Diagnosis
715.94	Osteoarthrosis, unspecified whether generalized or localized, hand	ICD-9-CM	Diagnosis
715.95	Osteoarthrosis, unspecified whether generalized or localized, pelvic region and thigh	ICD-9-CM	Diagnosis
715.96	Osteoarthrosis, unspecified whether generalized or localized, lower leg	ICD-9-CM	Diagnosis
715.97	Osteoarthrosis, unspecified whether generalized or localized, ankle and foot	ICD-9-CM	Diagnosis
715.98	Osteoarthrosis, unspecified whether generalized or localized, other specified sites	ICD-9-CM	Diagnosis
720.0	Ankylosing spondylitis	ICD-9-CM	Diagnosis
721.0	Cervical spondylosis without myelopathy	ICD-9-CM	Diagnosis
721.1	Cervical spondylosis with myelopathy	ICD-9-CM	Diagnosis
721.2	Thoracic spondylosis without myelopathy	ICD-9-CM	Diagnosis
721.3	Lumbosacral spondylosis without myelopathy	ICD-9-CM	Diagnosis
721.90	Spondylosis of unspecified site without mention of myelopathy	ICD-9-CM	Diagnosis
721.91	Spondylosis of unspecified site with myelopathy	ICD-9-CM	Diagnosis
M05.00	Felty's syndrome, unspecified site	ICD-10-CM	Diagnosis
M05.011	Felty's syndrome, right shoulder	ICD-10-CM	Diagnosis
M05.012	Felty's syndrome, left shoulder	ICD-10-CM	Diagnosis
M05.019	Felty's syndrome, unspecified shoulder	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M05.021	Felty's syndrome, right elbow	ICD-10-CM	Diagnosis
M05.022	Felty's syndrome, left elbow	ICD-10-CM	Diagnosis
M05.029	Felty's syndrome, unspecified elbow	ICD-10-CM	Diagnosis
M05.031	Felty's syndrome, right wrist	ICD-10-CM	Diagnosis
M05.032	Felty's syndrome, left wrist	ICD-10-CM	Diagnosis
M05.039	Felty's syndrome, unspecified wrist	ICD-10-CM	Diagnosis
M05.041	Felty's syndrome, right hand	ICD-10-CM	Diagnosis
M05.042	Felty's syndrome, left hand	ICD-10-CM	Diagnosis
M05.049	Felty's syndrome, unspecified hand	ICD-10-CM	Diagnosis
M05.051	Felty's syndrome, right hip	ICD-10-CM	Diagnosis
M05.052	Felty's syndrome, left hip	ICD-10-CM	Diagnosis
M05.059	Felty's syndrome, unspecified hip	ICD-10-CM	Diagnosis
M05.061	Felty's syndrome, right knee	ICD-10-CM	Diagnosis
M05.062	Felty's syndrome, left knee	ICD-10-CM	Diagnosis
M05.069	Felty's syndrome, unspecified knee	ICD-10-CM	Diagnosis
M05.071	Felty's syndrome, right ankle and foot	ICD-10-CM	Diagnosis
M05.072	Felty's syndrome, left ankle and foot	ICD-10-CM	Diagnosis
M05.079	Felty's syndrome, unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.09	Felty's syndrome, multiple sites	ICD-10-CM	Diagnosis
M05.20	Rheumatoid vasculitis with rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis
M05.211	Rheumatoid vasculitis with rheumatoid arthritis of right shoulder	ICD-10-CM	Diagnosis
M05.212	Rheumatoid vasculitis with rheumatoid arthritis of left shoulder	ICD-10-CM	Diagnosis
M05.219	Rheumatoid vasculitis with rheumatoid arthritis of unspecified shoulder	ICD-10-CM	Diagnosis
M05.221	Rheumatoid vasculitis with rheumatoid arthritis of right elbow	ICD-10-CM	Diagnosis
M05.222	Rheumatoid vasculitis with rheumatoid arthritis of left elbow	ICD-10-CM	Diagnosis
M05.229	Rheumatoid vasculitis with rheumatoid arthritis of unspecified elbow	ICD-10-CM	Diagnosis
M05.231	Rheumatoid vasculitis with rheumatoid arthritis of right wrist	ICD-10-CM	Diagnosis
M05.232	Rheumatoid vasculitis with rheumatoid arthritis of left wrist	ICD-10-CM	Diagnosis
M05.239	Rheumatoid vasculitis with rheumatoid arthritis of unspecified wrist	ICD-10-CM	Diagnosis
M05.241	Rheumatoid vasculitis with rheumatoid arthritis of right hand	ICD-10-CM	Diagnosis
M05.242	Rheumatoid vasculitis with rheumatoid arthritis of left hand	ICD-10-CM	Diagnosis
M05.249	Rheumatoid vasculitis with rheumatoid arthritis of unspecified hand	ICD-10-CM	Diagnosis
M05.251	Rheumatoid vasculitis with rheumatoid arthritis of right hip	ICD-10-CM	Diagnosis
M05.252	Rheumatoid vasculitis with rheumatoid arthritis of left hip	ICD-10-CM	Diagnosis
M05.259	Rheumatoid vasculitis with rheumatoid arthritis of unspecified hip	ICD-10-CM	Diagnosis
M05.261	Rheumatoid vasculitis with rheumatoid arthritis of right knee	ICD-10-CM	Diagnosis
M05.262	Rheumatoid vasculitis with rheumatoid arthritis of left knee	ICD-10-CM	Diagnosis
M05.269	Rheumatoid vasculitis with rheumatoid arthritis of unspecified knee	ICD-10-CM	Diagnosis
M05.271	Rheumatoid vasculitis with rheumatoid arthritis of right ankle and foot	ICD-10-CM	Diagnosis
M05.272	Rheumatoid vasculitis with rheumatoid arthritis of left ankle and foot	ICD-10-CM	Diagnosis
M05.279	Rheumatoid vasculitis with rheumatoid arthritis of unspecified ankle and foot	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M05.29	Rheumatoid vasculitis with rheumatoid arthritis of multiple sites	ICD-10-CM	Diagnosis
M05.30	Rheumatoid heart disease with rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis
M05.311	Rheumatoid heart disease with rheumatoid arthritis of right shoulder	ICD-10-CM	Diagnosis
M05.312	Rheumatoid heart disease with rheumatoid arthritis of left shoulder	ICD-10-CM	Diagnosis
M05.319	Rheumatoid heart disease with rheumatoid arthritis of unspecified shoulder	ICD-10-CM	Diagnosis
M05.321	Rheumatoid heart disease with rheumatoid arthritis of right elbow	ICD-10-CM	Diagnosis
M05.322	Rheumatoid heart disease with rheumatoid arthritis of left elbow	ICD-10-CM	Diagnosis
M05.329	Rheumatoid heart disease with rheumatoid arthritis of unspecified elbow	ICD-10-CM	Diagnosis
M05.331	Rheumatoid heart disease with rheumatoid arthritis of right wrist	ICD-10-CM	Diagnosis
M05.332	Rheumatoid heart disease with rheumatoid arthritis of left wrist	ICD-10-CM	Diagnosis
M05.339	Rheumatoid heart disease with rheumatoid arthritis of unspecified wrist	ICD-10-CM	Diagnosis
M05.341	Rheumatoid heart disease with rheumatoid arthritis of right hand	ICD-10-CM	Diagnosis
M05.342	Rheumatoid heart disease with rheumatoid arthritis of left hand	ICD-10-CM	Diagnosis
M05.349	Rheumatoid heart disease with rheumatoid arthritis of unspecified hand	ICD-10-CM	Diagnosis
M05.351	Rheumatoid heart disease with rheumatoid arthritis of right hip	ICD-10-CM	Diagnosis
M05.352	Rheumatoid heart disease with rheumatoid arthritis of left hip	ICD-10-CM	Diagnosis
M05.359	Rheumatoid heart disease with rheumatoid arthritis of unspecified hip	ICD-10-CM	Diagnosis
M05.361	Rheumatoid heart disease with rheumatoid arthritis of right knee	ICD-10-CM	Diagnosis
M05.362	Rheumatoid heart disease with rheumatoid arthritis of left knee	ICD-10-CM	Diagnosis
M05.369	Rheumatoid heart disease with rheumatoid arthritis of unspecified knee	ICD-10-CM	Diagnosis
M05.371	Rheumatoid heart disease with rheumatoid arthritis of right ankle and foot	ICD-10-CM	Diagnosis
M05.372	Rheumatoid heart disease with rheumatoid arthritis of left ankle and foot	ICD-10-CM	Diagnosis
M05.379	Rheumatoid heart disease with rheumatoid arthritis of unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.39	Rheumatoid heart disease with rheumatoid arthritis of multiple sites	ICD-10-CM	Diagnosis
M05.40	Rheumatoid myopathy with rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis
M05.411	Rheumatoid myopathy with rheumatoid arthritis of right shoulder	ICD-10-CM	Diagnosis
M05.412	Rheumatoid myopathy with rheumatoid arthritis of left shoulder	ICD-10-CM	Diagnosis
M05.419	Rheumatoid myopathy with rheumatoid arthritis of unspecified shoulder	ICD-10-CM	Diagnosis
M05.421	Rheumatoid myopathy with rheumatoid arthritis of right elbow	ICD-10-CM	Diagnosis
M05.422	Rheumatoid myopathy with rheumatoid arthritis of left elbow	ICD-10-CM	Diagnosis
M05.429	Rheumatoid myopathy with rheumatoid arthritis of unspecified elbow	ICD-10-CM	Diagnosis
M05.431	Rheumatoid myopathy with rheumatoid arthritis of right wrist	ICD-10-CM	Diagnosis
M05.432	Rheumatoid myopathy with rheumatoid arthritis of left wrist	ICD-10-CM	Diagnosis
M05.439	Rheumatoid myopathy with rheumatoid arthritis of unspecified wrist	ICD-10-CM	Diagnosis
M05.441	Rheumatoid myopathy with rheumatoid arthritis of right hand	ICD-10-CM	Diagnosis
M05.442	Rheumatoid myopathy with rheumatoid arthritis of left hand	ICD-10-CM	Diagnosis
M05.449	Rheumatoid myopathy with rheumatoid arthritis of unspecified hand	ICD-10-CM	Diagnosis
M05.451	Rheumatoid myopathy with rheumatoid arthritis of right hip	ICD-10-CM	Diagnosis
M05.452	Rheumatoid myopathy with rheumatoid arthritis of left hip	ICD-10-CM	Diagnosis
M05.459	Rheumatoid myopathy with rheumatoid arthritis of unspecified hip	ICD-10-CM	Diagnosis
M05.461	Rheumatoid myopathy with rheumatoid arthritis of right knee	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M05.462	Rheumatoid myopathy with rheumatoid arthritis of left knee	ICD-10-CM	Diagnosis
M05.469	Rheumatoid myopathy with rheumatoid arthritis of unspecified knee	ICD-10-CM	Diagnosis
M05.471	Rheumatoid myopathy with rheumatoid arthritis of right ankle and foot	ICD-10-CM	Diagnosis
M05.472	Rheumatoid myopathy with rheumatoid arthritis of left ankle and foot	ICD-10-CM	Diagnosis
M05.479	Rheumatoid myopathy with rheumatoid arthritis of unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.49	Rheumatoid myopathy with rheumatoid arthritis of multiple sites	ICD-10-CM	Diagnosis
M05.50	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis
M05.511	Rheumatoid polyneuropathy with rheumatoid arthritis of right shoulder	ICD-10-CM	Diagnosis
M05.512	Rheumatoid polyneuropathy with rheumatoid arthritis of left shoulder	ICD-10-CM	Diagnosis
M05.519	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified shoulder	ICD-10-CM	Diagnosis
M05.521	Rheumatoid polyneuropathy with rheumatoid arthritis of right elbow	ICD-10-CM	Diagnosis
M05.522	Rheumatoid polyneuropathy with rheumatoid arthritis of left elbow	ICD-10-CM	Diagnosis
M05.529	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified elbow	ICD-10-CM	Diagnosis
M05.531	Rheumatoid polyneuropathy with rheumatoid arthritis of right wrist	ICD-10-CM	Diagnosis
M05.532	Rheumatoid polyneuropathy with rheumatoid arthritis of left wrist	ICD-10-CM	Diagnosis
M05.539	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified wrist	ICD-10-CM	Diagnosis
M05.541	Rheumatoid polyneuropathy with rheumatoid arthritis of right hand	ICD-10-CM	Diagnosis
M05.542	Rheumatoid polyneuropathy with rheumatoid arthritis of left hand	ICD-10-CM	Diagnosis
M05.549	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hand	ICD-10-CM	Diagnosis
M05.551	Rheumatoid polyneuropathy with rheumatoid arthritis of right hip	ICD-10-CM	Diagnosis
M05.552	Rheumatoid polyneuropathy with rheumatoid arthritis of left hip	ICD-10-CM	Diagnosis
M05.559	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hip	ICD-10-CM	Diagnosis
M05.561	Rheumatoid polyneuropathy with rheumatoid arthritis of right knee	ICD-10-CM	Diagnosis
M05.562	Rheumatoid polyneuropathy with rheumatoid arthritis of left knee	ICD-10-CM	Diagnosis
M05.569	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified knee	ICD-10-CM	Diagnosis
M05.571	Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot	ICD-10-CM	Diagnosis
M05.572	Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot	ICD-10-CM	Diagnosis
M05.579	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.59	Rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites	ICD-10-CM	Diagnosis
M05.60	Rheumatoid arthritis of unspecified site with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.611	Rheumatoid arthritis of right shoulder with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.612	Rheumatoid arthritis of left shoulder with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.619	Rheumatoid arthritis of unspecified shoulder with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.621	Rheumatoid arthritis of right elbow with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.622	Rheumatoid arthritis of left elbow with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.629	Rheumatoid arthritis of unspecified elbow with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.631	Rheumatoid arthritis of right wrist with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.632	Rheumatoid arthritis of left wrist with involvement of other organs and systems	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M05.639	Rheumatoid arthritis of unspecified wrist with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.641	Rheumatoid arthritis of right hand with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.642	Rheumatoid arthritis of left hand with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.649	Rheumatoid arthritis of unspecified hand with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.651	Rheumatoid arthritis of right hip with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.652	Rheumatoid arthritis of left hip with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.659	Rheumatoid arthritis of unspecified hip with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.661	Rheumatoid arthritis of right knee with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.662	Rheumatoid arthritis of left knee with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.669	Rheumatoid arthritis of unspecified knee with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.671	Rheumatoid arthritis of right ankle and foot with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.672	Rheumatoid arthritis of left ankle and foot with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.679	Rheumatoid arthritis of unspecified ankle and foot with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.69	Rheumatoid arthritis of multiple sites with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.70	Rheumatoid arthritis with rheumatoid factor of unspecified site without organ or systems involvement	ICD-10-CM	Diagnosis
M05.711	Rheumatoid arthritis with rheumatoid factor of right shoulder without organ or systems involvement	ICD-10-CM	Diagnosis
M05.712	Rheumatoid arthritis with rheumatoid factor of left shoulder without organ or systems involvement	ICD-10-CM	Diagnosis
M05.719	Rheumatoid arthritis with rheumatoid factor of unspecified shoulder without organ or systems involvement	ICD-10-CM	Diagnosis
M05.721	Rheumatoid arthritis with rheumatoid factor of right elbow without organ or systems involvement	ICD-10-CM	Diagnosis
M05.722	Rheumatoid arthritis with rheumatoid factor of left elbow without organ or systems involvement	ICD-10-CM	Diagnosis
M05.729	Rheumatoid arthritis with rheumatoid factor of unspecified elbow without organ or systems involvement	ICD-10-CM	Diagnosis
M05.731	Rheumatoid arthritis with rheumatoid factor of right wrist without organ or systems involvement	ICD-10-CM	Diagnosis
M05.732	Rheumatoid arthritis with rheumatoid factor of left wrist without organ or systems involvement	ICD-10-CM	Diagnosis
M05.739	Rheumatoid arthritis with rheumatoid factor of unspecified wrist without organ or systems involvement	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M05.741	Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement	ICD-10-CM	Diagnosis
M05.742	Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement	ICD-10-CM	Diagnosis
M05.749	Rheumatoid arthritis with rheumatoid factor of unspecified hand without organ or systems involvement	ICD-10-CM	Diagnosis
M05.751	Rheumatoid arthritis with rheumatoid factor of right hip without organ or systems involvement	ICD-10-CM	Diagnosis
M05.752	Rheumatoid arthritis with rheumatoid factor of left hip without organ or systems involvement	ICD-10-CM	Diagnosis
M05.759	Rheumatoid arthritis with rheumatoid factor of unspecified hip without organ or systems involvement	ICD-10-CM	Diagnosis
M05.761	Rheumatoid arthritis with rheumatoid factor of right knee without organ or systems involvement	ICD-10-CM	Diagnosis
M05.762	Rheumatoid arthritis with rheumatoid factor of left knee without organ or systems involvement	ICD-10-CM	Diagnosis
M05.769	Rheumatoid arthritis with rheumatoid factor of unspecified knee without organ or systems involvement	ICD-10-CM	Diagnosis
M05.771	Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement	ICD-10-CM	Diagnosis
M05.772	Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement	ICD-10-CM	Diagnosis
M05.779	Rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot without organ or systems involvement	ICD-10-CM	Diagnosis
M05.79	Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement	ICD-10-CM	Diagnosis
M05.80	Other rheumatoid arthritis with rheumatoid factor of unspecified site	ICD-10-CM	Diagnosis
M05.811	Other rheumatoid arthritis with rheumatoid factor of right shoulder	ICD-10-CM	Diagnosis
M05.812	Other rheumatoid arthritis with rheumatoid factor of left shoulder	ICD-10-CM	Diagnosis
M05.819	Other rheumatoid arthritis with rheumatoid factor of unspecified shoulder	ICD-10-CM	Diagnosis
M05.821	Other rheumatoid arthritis with rheumatoid factor of right elbow	ICD-10-CM	Diagnosis
M05.822	Other rheumatoid arthritis with rheumatoid factor of left elbow	ICD-10-CM	Diagnosis
M05.829	Other rheumatoid arthritis with rheumatoid factor of unspecified elbow	ICD-10-CM	Diagnosis
M05.831	Other rheumatoid arthritis with rheumatoid factor of right wrist	ICD-10-CM	Diagnosis
M05.832	Other rheumatoid arthritis with rheumatoid factor of left wrist	ICD-10-CM	Diagnosis
M05.839	Other rheumatoid arthritis with rheumatoid factor of unspecified wrist	ICD-10-CM	Diagnosis
M05.841	Other rheumatoid arthritis with rheumatoid factor of right hand	ICD-10-CM	Diagnosis
M05.842	Other rheumatoid arthritis with rheumatoid factor of left hand	ICD-10-CM	Diagnosis
M05.849	Other rheumatoid arthritis with rheumatoid factor of unspecified hand	ICD-10-CM	Diagnosis
M05.851	Other rheumatoid arthritis with rheumatoid factor of right hip	ICD-10-CM	Diagnosis
M05.852	Other rheumatoid arthritis with rheumatoid factor of left hip	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M05.859	Other rheumatoid arthritis with rheumatoid factor of unspecified hip	ICD-10-CM	Diagnosis
M05.861	Other rheumatoid arthritis with rheumatoid factor of right knee	ICD-10-CM	Diagnosis
M05.862	Other rheumatoid arthritis with rheumatoid factor of left knee	ICD-10-CM	Diagnosis
M05.869	Other rheumatoid arthritis with rheumatoid factor of unspecified knee	ICD-10-CM	Diagnosis
M05.871	Other rheumatoid arthritis with rheumatoid factor of right ankle and foot	ICD-10-CM	Diagnosis
M05.872	Other rheumatoid arthritis with rheumatoid factor of left ankle and foot	ICD-10-CM	Diagnosis
M05.879	Other rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.89	Other rheumatoid arthritis with rheumatoid factor of multiple sites	ICD-10-CM	Diagnosis
M05.9	Rheumatoid arthritis with rheumatoid factor, unspecified	ICD-10-CM	Diagnosis
M06.00	Rheumatoid arthritis without rheumatoid factor, unspecified site	ICD-10-CM	Diagnosis
M06.011	Rheumatoid arthritis without rheumatoid factor, right shoulder	ICD-10-CM	Diagnosis
M06.012	Rheumatoid arthritis without rheumatoid factor, left shoulder	ICD-10-CM	Diagnosis
M06.019	Rheumatoid arthritis without rheumatoid factor, unspecified shoulder	ICD-10-CM	Diagnosis
M06.021	Rheumatoid arthritis without rheumatoid factor, right elbow	ICD-10-CM	Diagnosis
M06.022	Rheumatoid arthritis without rheumatoid factor, left elbow	ICD-10-CM	Diagnosis
M06.029	Rheumatoid arthritis without rheumatoid factor, unspecified elbow	ICD-10-CM	Diagnosis
M06.031	Rheumatoid arthritis without rheumatoid factor, right wrist	ICD-10-CM	Diagnosis
M06.032	Rheumatoid arthritis without rheumatoid factor, left wrist	ICD-10-CM	Diagnosis
M06.039	Rheumatoid arthritis without rheumatoid factor, unspecified wrist	ICD-10-CM	Diagnosis
M06.041	Rheumatoid arthritis without rheumatoid factor, right hand	ICD-10-CM	Diagnosis
M06.042	Rheumatoid arthritis without rheumatoid factor, left hand	ICD-10-CM	Diagnosis
M06.049	Rheumatoid arthritis without rheumatoid factor, unspecified hand	ICD-10-CM	Diagnosis
M06.051	Rheumatoid arthritis without rheumatoid factor, right hip	ICD-10-CM	Diagnosis
M06.052	Rheumatoid arthritis without rheumatoid factor, left hip	ICD-10-CM	Diagnosis
M06.059	Rheumatoid arthritis without rheumatoid factor, unspecified hip	ICD-10-CM	Diagnosis
M06.061	Rheumatoid arthritis without rheumatoid factor, right knee	ICD-10-CM	Diagnosis
M06.062	Rheumatoid arthritis without rheumatoid factor, left knee	ICD-10-CM	Diagnosis
M06.069	Rheumatoid arthritis without rheumatoid factor, unspecified knee	ICD-10-CM	Diagnosis
M06.071	Rheumatoid arthritis without rheumatoid factor, right ankle and foot	ICD-10-CM	Diagnosis
M06.072	Rheumatoid arthritis without rheumatoid factor, left ankle and foot	ICD-10-CM	Diagnosis
M06.079	Rheumatoid arthritis without rheumatoid factor, unspecified ankle and foot	ICD-10-CM	Diagnosis
M06.08	Rheumatoid arthritis without rheumatoid factor, vertebrae	ICD-10-CM	Diagnosis
M06.09	Rheumatoid arthritis without rheumatoid factor, multiple sites	ICD-10-CM	Diagnosis
M06.1	Adult-onset Still's disease	ICD-10-CM	Diagnosis
M06.20	Rheumatoid bursitis, unspecified site	ICD-10-CM	Diagnosis
M06.211	Rheumatoid bursitis, right shoulder	ICD-10-CM	Diagnosis
M06.212	Rheumatoid bursitis, left shoulder	ICD-10-CM	Diagnosis
M06.219	Rheumatoid bursitis, unspecified shoulder	ICD-10-CM	Diagnosis
M06.221	Rheumatoid bursitis, right elbow	ICD-10-CM	Diagnosis
M06.222	Rheumatoid bursitis, left elbow	ICD-10-CM	Diagnosis
M06.229	Rheumatoid bursitis, unspecified elbow	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M06.231	Rheumatoid bursitis, right wrist	ICD-10-CM	Diagnosis
M06.232	Rheumatoid bursitis, left wrist	ICD-10-CM	Diagnosis
M06.239	Rheumatoid bursitis, unspecified wrist	ICD-10-CM	Diagnosis
M06.241	Rheumatoid bursitis, right hand	ICD-10-CM	Diagnosis
M06.242	Rheumatoid bursitis, left hand	ICD-10-CM	Diagnosis
M06.249	Rheumatoid bursitis, unspecified hand	ICD-10-CM	Diagnosis
M06.251	Rheumatoid bursitis, right hip	ICD-10-CM	Diagnosis
M06.252	Rheumatoid bursitis, left hip	ICD-10-CM	Diagnosis
M06.259	Rheumatoid bursitis, unspecified hip	ICD-10-CM	Diagnosis
M06.261	Rheumatoid bursitis, right knee	ICD-10-CM	Diagnosis
M06.262	Rheumatoid bursitis, left knee	ICD-10-CM	Diagnosis
M06.269	Rheumatoid bursitis, unspecified knee	ICD-10-CM	Diagnosis
M06.271	Rheumatoid bursitis, right ankle and foot	ICD-10-CM	Diagnosis
M06.272	Rheumatoid bursitis, left ankle and foot	ICD-10-CM	Diagnosis
M06.279	Rheumatoid bursitis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M06.28	Rheumatoid bursitis, vertebrae	ICD-10-CM	Diagnosis
M06.29	Rheumatoid bursitis, multiple sites	ICD-10-CM	Diagnosis
M06.30	Rheumatoid nodule, unspecified site	ICD-10-CM	Diagnosis
M06.311	Rheumatoid nodule, right shoulder	ICD-10-CM	Diagnosis
M06.312	Rheumatoid nodule, left shoulder	ICD-10-CM	Diagnosis
M06.319	Rheumatoid nodule, unspecified shoulder	ICD-10-CM	Diagnosis
M06.321	Rheumatoid nodule, right elbow	ICD-10-CM	Diagnosis
M06.322	Rheumatoid nodule, left elbow	ICD-10-CM	Diagnosis
M06.329	Rheumatoid nodule, unspecified elbow	ICD-10-CM	Diagnosis
M06.331	Rheumatoid nodule, right wrist	ICD-10-CM	Diagnosis
M06.332	Rheumatoid nodule, left wrist	ICD-10-CM	Diagnosis
M06.339	Rheumatoid nodule, unspecified wrist	ICD-10-CM	Diagnosis
M06.341	Rheumatoid nodule, right hand	ICD-10-CM	Diagnosis
M06.342	Rheumatoid nodule, left hand	ICD-10-CM	Diagnosis
M06.349	Rheumatoid nodule, unspecified hand	ICD-10-CM	Diagnosis
M06.351	Rheumatoid nodule, right hip	ICD-10-CM	Diagnosis
M06.352	Rheumatoid nodule, left hip	ICD-10-CM	Diagnosis
M06.359	Rheumatoid nodule, unspecified hip	ICD-10-CM	Diagnosis
M06.361	Rheumatoid nodule, right knee	ICD-10-CM	Diagnosis
M06.362	Rheumatoid nodule, left knee	ICD-10-CM	Diagnosis
M06.369	Rheumatoid nodule, unspecified knee	ICD-10-CM	Diagnosis
M06.371	Rheumatoid nodule, right ankle and foot	ICD-10-CM	Diagnosis
M06.372	Rheumatoid nodule, left ankle and foot	ICD-10-CM	Diagnosis
M06.379	Rheumatoid nodule, unspecified ankle and foot	ICD-10-CM	Diagnosis
M06.38	Rheumatoid nodule, vertebrae	ICD-10-CM	Diagnosis
M06.39	Rheumatoid nodule, multiple sites	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M06.80	Other specified rheumatoid arthritis, unspecified site	ICD-10-CM	Diagnosis
M06.811	Other specified rheumatoid arthritis, right shoulder	ICD-10-CM	Diagnosis
M06.812	Other specified rheumatoid arthritis, left shoulder	ICD-10-CM	Diagnosis
M06.819	Other specified rheumatoid arthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M06.821	Other specified rheumatoid arthritis, right elbow	ICD-10-CM	Diagnosis
M06.822	Other specified rheumatoid arthritis, left elbow	ICD-10-CM	Diagnosis
M06.829	Other specified rheumatoid arthritis, unspecified elbow	ICD-10-CM	Diagnosis
M06.831	Other specified rheumatoid arthritis, right wrist	ICD-10-CM	Diagnosis
M06.832	Other specified rheumatoid arthritis, left wrist	ICD-10-CM	Diagnosis
M06.839	Other specified rheumatoid arthritis, unspecified wrist	ICD-10-CM	Diagnosis
M06.841	Other specified rheumatoid arthritis, right hand	ICD-10-CM	Diagnosis
M06.842	Other specified rheumatoid arthritis, left hand	ICD-10-CM	Diagnosis
M06.849	Other specified rheumatoid arthritis, unspecified hand	ICD-10-CM	Diagnosis
M06.851	Other specified rheumatoid arthritis, right hip	ICD-10-CM	Diagnosis
M06.852	Other specified rheumatoid arthritis, left hip	ICD-10-CM	Diagnosis
M06.859	Other specified rheumatoid arthritis, unspecified hip	ICD-10-CM	Diagnosis
M06.861	Other specified rheumatoid arthritis, right knee	ICD-10-CM	Diagnosis
M06.862	Other specified rheumatoid arthritis, left knee	ICD-10-CM	Diagnosis
M06.869	Other specified rheumatoid arthritis, unspecified knee	ICD-10-CM	Diagnosis
M06.871	Other specified rheumatoid arthritis, right ankle and foot	ICD-10-CM	Diagnosis
M06.872	Other specified rheumatoid arthritis, left ankle and foot	ICD-10-CM	Diagnosis
M06.879	Other specified rheumatoid arthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M06.88	Other specified rheumatoid arthritis, vertebrae	ICD-10-CM	Diagnosis
M06.89	Other specified rheumatoid arthritis, multiple sites	ICD-10-CM	Diagnosis
M06.9	Rheumatoid arthritis, unspecified	ICD-10-CM	Diagnosis
M08.00	Unspecified juvenile rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis
M08.011	Unspecified juvenile rheumatoid arthritis, right shoulder	ICD-10-CM	Diagnosis
M08.012	Unspecified juvenile rheumatoid arthritis, left shoulder	ICD-10-CM	Diagnosis
M08.019	Unspecified juvenile rheumatoid arthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M08.021	Unspecified juvenile rheumatoid arthritis, right elbow	ICD-10-CM	Diagnosis
M08.022	Unspecified juvenile rheumatoid arthritis, left elbow	ICD-10-CM	Diagnosis
M08.029	Unspecified juvenile rheumatoid arthritis, unspecified elbow	ICD-10-CM	Diagnosis
M08.031	Unspecified juvenile rheumatoid arthritis, right wrist	ICD-10-CM	Diagnosis
M08.032	Unspecified juvenile rheumatoid arthritis, left wrist	ICD-10-CM	Diagnosis
M08.039	Unspecified juvenile rheumatoid arthritis, unspecified wrist	ICD-10-CM	Diagnosis
M08.041	Unspecified juvenile rheumatoid arthritis, right hand	ICD-10-CM	Diagnosis
M08.042	Unspecified juvenile rheumatoid arthritis, left hand	ICD-10-CM	Diagnosis
M08.049	Unspecified juvenile rheumatoid arthritis, unspecified hand	ICD-10-CM	Diagnosis
M08.051	Unspecified juvenile rheumatoid arthritis, right hip	ICD-10-CM	Diagnosis
M08.052	Unspecified juvenile rheumatoid arthritis, left hip	ICD-10-CM	Diagnosis
M08.059	Unspecified juvenile rheumatoid arthritis, unspecified hip	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M08.061	Unspecified juvenile rheumatoid arthritis, right knee	ICD-10-CM	Diagnosis
M08.062	Unspecified juvenile rheumatoid arthritis, left knee	ICD-10-CM	Diagnosis
M08.069	Unspecified juvenile rheumatoid arthritis, unspecified knee	ICD-10-CM	Diagnosis
M08.071	Unspecified juvenile rheumatoid arthritis, right ankle and foot	ICD-10-CM	Diagnosis
M08.072	Unspecified juvenile rheumatoid arthritis, left ankle and foot	ICD-10-CM	Diagnosis
M08.079	Unspecified juvenile rheumatoid arthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M08.08	Unspecified juvenile rheumatoid arthritis, vertebrae	ICD-10-CM	Diagnosis
M08.09	Unspecified juvenile rheumatoid arthritis, multiple sites	ICD-10-CM	Diagnosis
M08.1	Juvenile ankylosing spondylitis	ICD-10-CM	Diagnosis
M08.20	Juvenile rheumatoid arthritis with systemic onset, unspecified site	ICD-10-CM	Diagnosis
M08.211	Juvenile rheumatoid arthritis with systemic onset, right shoulder	ICD-10-CM	Diagnosis
M08.212	Juvenile rheumatoid arthritis with systemic onset, left shoulder	ICD-10-CM	Diagnosis
M08.219	Juvenile rheumatoid arthritis with systemic onset, unspecified shoulder	ICD-10-CM	Diagnosis
M08.221	Juvenile rheumatoid arthritis with systemic onset, right elbow	ICD-10-CM	Diagnosis
M08.222	Juvenile rheumatoid arthritis with systemic onset, left elbow	ICD-10-CM	Diagnosis
M08.229	Juvenile rheumatoid arthritis with systemic onset, unspecified elbow	ICD-10-CM	Diagnosis
M08.231	Juvenile rheumatoid arthritis with systemic onset, right wrist	ICD-10-CM	Diagnosis
M08.232	Juvenile rheumatoid arthritis with systemic onset, left wrist	ICD-10-CM	Diagnosis
M08.239	Juvenile rheumatoid arthritis with systemic onset, unspecified wrist	ICD-10-CM	Diagnosis
M08.241	Juvenile rheumatoid arthritis with systemic onset, right hand	ICD-10-CM	Diagnosis
M08.242	Juvenile rheumatoid arthritis with systemic onset, left hand	ICD-10-CM	Diagnosis
M08.249	Juvenile rheumatoid arthritis with systemic onset, unspecified hand	ICD-10-CM	Diagnosis
M08.251	Juvenile rheumatoid arthritis with systemic onset, right hip	ICD-10-CM	Diagnosis
M08.252	Juvenile rheumatoid arthritis with systemic onset, left hip	ICD-10-CM	Diagnosis
M08.259	Juvenile rheumatoid arthritis with systemic onset, unspecified hip	ICD-10-CM	Diagnosis
M08.261	Juvenile rheumatoid arthritis with systemic onset, right knee	ICD-10-CM	Diagnosis
M08.262	Juvenile rheumatoid arthritis with systemic onset, left knee	ICD-10-CM	Diagnosis
M08.269	Juvenile rheumatoid arthritis with systemic onset, unspecified knee	ICD-10-CM	Diagnosis
M08.271	Juvenile rheumatoid arthritis with systemic onset, right ankle and foot	ICD-10-CM	Diagnosis
M08.272	Juvenile rheumatoid arthritis with systemic onset, left ankle and foot	ICD-10-CM	Diagnosis
M08.279	Juvenile rheumatoid arthritis with systemic onset, unspecified ankle and foot	ICD-10-CM	Diagnosis
M08.28	Juvenile rheumatoid arthritis with systemic onset, vertebrae	ICD-10-CM	Diagnosis
M08.29	Juvenile rheumatoid arthritis with systemic onset, multiple sites	ICD-10-CM	Diagnosis
M08.3	Juvenile rheumatoid polyarthritis (seronegative)	ICD-10-CM	Diagnosis
M08.40	Pauciarticular juvenile rheumatoid arthritis, unspecified site	ICD-10-CM	Diagnosis
M08.411	Pauciarticular juvenile rheumatoid arthritis, right shoulder	ICD-10-CM	Diagnosis
M08.412	Pauciarticular juvenile rheumatoid arthritis, left shoulder	ICD-10-CM	Diagnosis
M08.419	Pauciarticular juvenile rheumatoid arthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M08.421	Pauciarticular juvenile rheumatoid arthritis, right elbow	ICD-10-CM	Diagnosis
M08.422	Pauciarticular juvenile rheumatoid arthritis, left elbow	ICD-10-CM	Diagnosis
M08.429	Pauciarticular juvenile rheumatoid arthritis, unspecified elbow	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M08.431	Pauciarticular juvenile rheumatoid arthritis, right wrist	ICD-10-CM	Diagnosis
M08.432	Pauciarticular juvenile rheumatoid arthritis, left wrist	ICD-10-CM	Diagnosis
M08.439	Pauciarticular juvenile rheumatoid arthritis, unspecified wrist	ICD-10-CM	Diagnosis
M08.441	Pauciarticular juvenile rheumatoid arthritis, right hand	ICD-10-CM	Diagnosis
M08.442	Pauciarticular juvenile rheumatoid arthritis, left hand	ICD-10-CM	Diagnosis
M08.449	Pauciarticular juvenile rheumatoid arthritis, unspecified hand	ICD-10-CM	Diagnosis
M08.451	Pauciarticular juvenile rheumatoid arthritis, right hip	ICD-10-CM	Diagnosis
M08.452	Pauciarticular juvenile rheumatoid arthritis, left hip	ICD-10-CM	Diagnosis
M08.459	Pauciarticular juvenile rheumatoid arthritis, unspecified hip	ICD-10-CM	Diagnosis
M08.461	Pauciarticular juvenile rheumatoid arthritis, right knee	ICD-10-CM	Diagnosis
M08.462	Pauciarticular juvenile rheumatoid arthritis, left knee	ICD-10-CM	Diagnosis
M08.469	Pauciarticular juvenile rheumatoid arthritis, unspecified knee	ICD-10-CM	Diagnosis
M08.471	Pauciarticular juvenile rheumatoid arthritis, right ankle and foot	ICD-10-CM	Diagnosis
M08.472	Pauciarticular juvenile rheumatoid arthritis, left ankle and foot	ICD-10-CM	Diagnosis
M08.479	Pauciarticular juvenile rheumatoid arthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M08.48	Pauciarticular juvenile rheumatoid arthritis, vertebrae	ICD-10-CM	Diagnosis
M08.80	Other juvenile arthritis, unspecified site	ICD-10-CM	Diagnosis
M08.811	Other juvenile arthritis, right shoulder	ICD-10-CM	Diagnosis
M08.812	Other juvenile arthritis, left shoulder	ICD-10-CM	Diagnosis
M08.819	Other juvenile arthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M08.821	Other juvenile arthritis, right elbow	ICD-10-CM	Diagnosis
M08.822	Other juvenile arthritis, left elbow	ICD-10-CM	Diagnosis
M08.829	Other juvenile arthritis, unspecified elbow	ICD-10-CM	Diagnosis
M08.831	Other juvenile arthritis, right wrist	ICD-10-CM	Diagnosis
M08.832	Other juvenile arthritis, left wrist	ICD-10-CM	Diagnosis
M08.839	Other juvenile arthritis, unspecified wrist	ICD-10-CM	Diagnosis
M08.841	Other juvenile arthritis, right hand	ICD-10-CM	Diagnosis
M08.842	Other juvenile arthritis, left hand	ICD-10-CM	Diagnosis
M08.849	Other juvenile arthritis, unspecified hand	ICD-10-CM	Diagnosis
M08.851	Other juvenile arthritis, right hip	ICD-10-CM	Diagnosis
M08.852	Other juvenile arthritis, left hip	ICD-10-CM	Diagnosis
M08.859	Other juvenile arthritis, unspecified hip	ICD-10-CM	Diagnosis
M08.861	Other juvenile arthritis, right knee	ICD-10-CM	Diagnosis
M08.862	Other juvenile arthritis, left knee	ICD-10-CM	Diagnosis
M08.869	Other juvenile arthritis, unspecified knee	ICD-10-CM	Diagnosis
M08.871	Other juvenile arthritis, right ankle and foot	ICD-10-CM	Diagnosis
M08.872	Other juvenile arthritis, left ankle and foot	ICD-10-CM	Diagnosis
M08.879	Other juvenile arthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M08.88	Other juvenile arthritis, other specified site	ICD-10-CM	Diagnosis
M08.89	Other juvenile arthritis, multiple sites	ICD-10-CM	Diagnosis
M08.90	Juvenile arthritis, unspecified, unspecified site	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M08.911	Juvenile arthritis, unspecified, right shoulder	ICD-10-CM	Diagnosis
M08.912	Juvenile arthritis, unspecified, left shoulder	ICD-10-CM	Diagnosis
M08.919	Juvenile arthritis, unspecified, unspecified shoulder	ICD-10-CM	Diagnosis
M08.921	Juvenile arthritis, unspecified, right elbow	ICD-10-CM	Diagnosis
M08.922	Juvenile arthritis, unspecified, left elbow	ICD-10-CM	Diagnosis
M08.929	Juvenile arthritis, unspecified, unspecified elbow	ICD-10-CM	Diagnosis
M08.931	Juvenile arthritis, unspecified, right wrist	ICD-10-CM	Diagnosis
M08.932	Juvenile arthritis, unspecified, left wrist	ICD-10-CM	Diagnosis
M08.939	Juvenile arthritis, unspecified, unspecified wrist	ICD-10-CM	Diagnosis
M08.941	Juvenile arthritis, unspecified, right hand	ICD-10-CM	Diagnosis
M08.942	Juvenile arthritis, unspecified, left hand	ICD-10-CM	Diagnosis
M08.949	Juvenile arthritis, unspecified, unspecified hand	ICD-10-CM	Diagnosis
M08.951	Juvenile arthritis, unspecified, right hip	ICD-10-CM	Diagnosis
M08.952	Juvenile arthritis, unspecified, left hip	ICD-10-CM	Diagnosis
M08.959	Juvenile arthritis, unspecified, unspecified hip	ICD-10-CM	Diagnosis
M08.961	Juvenile arthritis, unspecified, right knee	ICD-10-CM	Diagnosis
M08.962	Juvenile arthritis, unspecified, left knee	ICD-10-CM	Diagnosis
M08.969	Juvenile arthritis, unspecified, unspecified knee	ICD-10-CM	Diagnosis
M08.971	Juvenile arthritis, unspecified, right ankle and foot	ICD-10-CM	Diagnosis
M08.972	Juvenile arthritis, unspecified, left ankle and foot	ICD-10-CM	Diagnosis
M08.979	Juvenile arthritis, unspecified, unspecified ankle and foot	ICD-10-CM	Diagnosis
M08.98	Juvenile arthritis, unspecified, vertebrae	ICD-10-CM	Diagnosis
M08.99	Juvenile arthritis, unspecified, multiple sites	ICD-10-CM	Diagnosis
M15.0	Primary generalized (osteo)arthritis	ICD-10-CM	Diagnosis
M15.1	Heberden's nodes (with arthropathy)	ICD-10-CM	Diagnosis
M15.2	Bouchard's nodes (with arthropathy)	ICD-10-CM	Diagnosis
M15.3	Secondary multiple arthritis	ICD-10-CM	Diagnosis
M15.4	Erosive (osteo)arthritis	ICD-10-CM	Diagnosis
M15.8	Other polyosteoarthritis	ICD-10-CM	Diagnosis
M15.9	Polyosteoarthritis, unspecified	ICD-10-CM	Diagnosis
M16.0	Bilateral primary osteoarthritis of hip	ICD-10-CM	Diagnosis
M16.10	Unilateral primary osteoarthritis, unspecified hip	ICD-10-CM	Diagnosis
M16.11	Unilateral primary osteoarthritis, right hip	ICD-10-CM	Diagnosis
M16.12	Unilateral primary osteoarthritis, left hip	ICD-10-CM	Diagnosis
M16.2	Bilateral osteoarthritis resulting from hip dysplasia	ICD-10-CM	Diagnosis
M16.30	Unilateral osteoarthritis resulting from hip dysplasia, unspecified hip	ICD-10-CM	Diagnosis
M16.31	Unilateral osteoarthritis resulting from hip dysplasia, right hip	ICD-10-CM	Diagnosis
M16.32	Unilateral osteoarthritis resulting from hip dysplasia, left hip	ICD-10-CM	Diagnosis
M16.4	Bilateral post-traumatic osteoarthritis of hip	ICD-10-CM	Diagnosis
M16.50	Unilateral post-traumatic osteoarthritis, unspecified hip	ICD-10-CM	Diagnosis
M16.51	Unilateral post-traumatic osteoarthritis, right hip	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M16.52	Unilateral post-traumatic osteoarthritis, left hip	ICD-10-CM	Diagnosis
M16.6	Other bilateral secondary osteoarthritis of hip	ICD-10-CM	Diagnosis
M16.7	Other unilateral secondary osteoarthritis of hip	ICD-10-CM	Diagnosis
M16.9	Osteoarthritis of hip, unspecified	ICD-10-CM	Diagnosis
M17.0	Bilateral primary osteoarthritis of knee	ICD-10-CM	Diagnosis
M17.10	Unilateral primary osteoarthritis, unspecified knee	ICD-10-CM	Diagnosis
M17.11	Unilateral primary osteoarthritis, right knee	ICD-10-CM	Diagnosis
M17.12	Unilateral primary osteoarthritis, left knee	ICD-10-CM	Diagnosis
M17.2	Bilateral post-traumatic osteoarthritis of knee	ICD-10-CM	Diagnosis
M17.30	Unilateral post-traumatic osteoarthritis, unspecified knee	ICD-10-CM	Diagnosis
M17.31	Unilateral post-traumatic osteoarthritis, right knee	ICD-10-CM	Diagnosis
M17.32	Unilateral post-traumatic osteoarthritis, left knee	ICD-10-CM	Diagnosis
M17.4	Other bilateral secondary osteoarthritis of knee	ICD-10-CM	Diagnosis
M17.5	Other unilateral secondary osteoarthritis of knee	ICD-10-CM	Diagnosis
M17.9	Osteoarthritis of knee, unspecified	ICD-10-CM	Diagnosis
M18.0	Bilateral primary osteoarthritis of first carpometacarpal joints	ICD-10-CM	Diagnosis
M18.10	Unilateral primary osteoarthritis of first carpometacarpal joint, unspecified hand	ICD-10-CM	Diagnosis
M18.11	Unilateral primary osteoarthritis of first carpometacarpal joint, right hand	ICD-10-CM	Diagnosis
M18.12	Unilateral primary osteoarthritis of first carpometacarpal joint, left hand	ICD-10-CM	Diagnosis
M18.2	Bilateral post-traumatic osteoarthritis of first carpometacarpal joints	ICD-10-CM	Diagnosis
M18.30	Unilateral post-traumatic osteoarthritis of first carpometacarpal joint, unspecified hand	ICD-10-CM	Diagnosis
M18.31	Unilateral post-traumatic osteoarthritis of first carpometacarpal joint, right hand	ICD-10-CM	Diagnosis
M18.32	Unilateral post-traumatic osteoarthritis of first carpometacarpal joint, left hand	ICD-10-CM	Diagnosis
M18.4	Other bilateral secondary osteoarthritis of first carpometacarpal joints	ICD-10-CM	Diagnosis
M18.50	Other unilateral secondary osteoarthritis of first carpometacarpal joint, unspecified hand	ICD-10-CM	Diagnosis
M18.51	Other unilateral secondary osteoarthritis of first carpometacarpal joint, right hand	ICD-10-CM	Diagnosis
M18.52	Other unilateral secondary osteoarthritis of first carpometacarpal joint, left hand	ICD-10-CM	Diagnosis
M18.9	Osteoarthritis of first carpometacarpal joint, unspecified	ICD-10-CM	Diagnosis
M19.011	Primary osteoarthritis, right shoulder	ICD-10-CM	Diagnosis
M19.012	Primary osteoarthritis, left shoulder	ICD-10-CM	Diagnosis
M19.019	Primary osteoarthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M19.021	Primary osteoarthritis, right elbow	ICD-10-CM	Diagnosis
M19.022	Primary osteoarthritis, left elbow	ICD-10-CM	Diagnosis
M19.029	Primary osteoarthritis, unspecified elbow	ICD-10-CM	Diagnosis
M19.031	Primary osteoarthritis, right wrist	ICD-10-CM	Diagnosis
M19.032	Primary osteoarthritis, left wrist	ICD-10-CM	Diagnosis
M19.039	Primary osteoarthritis, unspecified wrist	ICD-10-CM	Diagnosis
M19.041	Primary osteoarthritis, right hand	ICD-10-CM	Diagnosis
M19.042	Primary osteoarthritis, left hand	ICD-10-CM	Diagnosis
M19.049	Primary osteoarthritis, unspecified hand	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M19.071	Primary osteoarthritis, right ankle and foot	ICD-10-CM	Diagnosis
M19.072	Primary osteoarthritis, left ankle and foot	ICD-10-CM	Diagnosis
M19.079	Primary osteoarthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M19.111	Post-traumatic osteoarthritis, right shoulder	ICD-10-CM	Diagnosis
M19.112	Post-traumatic osteoarthritis, left shoulder	ICD-10-CM	Diagnosis
M19.119	Post-traumatic osteoarthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M19.121	Post-traumatic osteoarthritis, right elbow	ICD-10-CM	Diagnosis
M19.122	Post-traumatic osteoarthritis, left elbow	ICD-10-CM	Diagnosis
M19.129	Post-traumatic osteoarthritis, unspecified elbow	ICD-10-CM	Diagnosis
M19.131	Post-traumatic osteoarthritis, right wrist	ICD-10-CM	Diagnosis
M19.132	Post-traumatic osteoarthritis, left wrist	ICD-10-CM	Diagnosis
M19.139	Post-traumatic osteoarthritis, unspecified wrist	ICD-10-CM	Diagnosis
M19.141	Post-traumatic osteoarthritis, right hand	ICD-10-CM	Diagnosis
M19.142	Post-traumatic osteoarthritis, left hand	ICD-10-CM	Diagnosis
M19.149	Post-traumatic osteoarthritis, unspecified hand	ICD-10-CM	Diagnosis
M19.171	Post-traumatic osteoarthritis, right ankle and foot	ICD-10-CM	Diagnosis
M19.172	Post-traumatic osteoarthritis, left ankle and foot	ICD-10-CM	Diagnosis
M19.179	Post-traumatic osteoarthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M19.211	Secondary osteoarthritis, right shoulder	ICD-10-CM	Diagnosis
M19.212	Secondary osteoarthritis, left shoulder	ICD-10-CM	Diagnosis
M19.219	Secondary osteoarthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M19.221	Secondary osteoarthritis, right elbow	ICD-10-CM	Diagnosis
M19.222	Secondary osteoarthritis, left elbow	ICD-10-CM	Diagnosis
M19.229	Secondary osteoarthritis, unspecified elbow	ICD-10-CM	Diagnosis
M19.231	Secondary osteoarthritis, right wrist	ICD-10-CM	Diagnosis
M19.232	Secondary osteoarthritis, left wrist	ICD-10-CM	Diagnosis
M19.239	Secondary osteoarthritis, unspecified wrist	ICD-10-CM	Diagnosis
M19.241	Secondary osteoarthritis, right hand	ICD-10-CM	Diagnosis
M19.242	Secondary osteoarthritis, left hand	ICD-10-CM	Diagnosis
M19.249	Secondary osteoarthritis, unspecified hand	ICD-10-CM	Diagnosis
M19.271	Secondary osteoarthritis, right ankle and foot	ICD-10-CM	Diagnosis
M19.272	Secondary osteoarthritis, left ankle and foot	ICD-10-CM	Diagnosis
M19.279	Secondary osteoarthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M19.90	Unspecified osteoarthritis, unspecified site	ICD-10-CM	Diagnosis
M19.91	Primary osteoarthritis, unspecified site	ICD-10-CM	Diagnosis
M19.92	Post-traumatic osteoarthritis, unspecified site	ICD-10-CM	Diagnosis
M19.93	Secondary osteoarthritis, unspecified site	ICD-10-CM	Diagnosis
M45.0	Ankylosing spondylitis of multiple sites in spine	ICD-10-CM	Diagnosis
M45.1	Ankylosing spondylitis of occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M45.2	Ankylosing spondylitis of cervical region	ICD-10-CM	Diagnosis
M45.3	Ankylosing spondylitis of cervicothoracic region	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M45.4	Ankylosing spondylitis of thoracic region	ICD-10-CM	Diagnosis
M45.5	Ankylosing spondylitis of thoracolumbar region	ICD-10-CM	Diagnosis
M45.6	Ankylosing spondylitis lumbar region	ICD-10-CM	Diagnosis
M45.7	Ankylosing spondylitis of lumbosacral region	ICD-10-CM	Diagnosis
M45.8	Ankylosing spondylitis sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M45.9	Ankylosing spondylitis of unspecified sites in spine	ICD-10-CM	Diagnosis
M47.011	Anterior spinal artery compression syndromes, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.012	Anterior spinal artery compression syndromes, cervical region	ICD-10-CM	Diagnosis
M47.013	Anterior spinal artery compression syndromes, cervicothoracic region	ICD-10-CM	Diagnosis
M47.014	Anterior spinal artery compression syndromes, thoracic region	ICD-10-CM	Diagnosis
M47.015	Anterior spinal artery compression syndromes, thoracolumbar region	ICD-10-CM	Diagnosis
M47.016	Anterior spinal artery compression syndromes, lumbar region	ICD-10-CM	Diagnosis
M47.019	Anterior spinal artery compression syndromes, site unspecified	ICD-10-CM	Diagnosis
M47.021	Vertebral artery compression syndromes, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.022	Vertebral artery compression syndromes, cervical region	ICD-10-CM	Diagnosis
M47.029	Vertebral artery compression syndromes, site unspecified	ICD-10-CM	Diagnosis
M47.10	Other spondylosis with myelopathy, site unspecified	ICD-10-CM	Diagnosis
M47.11	Other spondylosis with myelopathy, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.12	Other spondylosis with myelopathy, cervical region	ICD-10-CM	Diagnosis
M47.13	Other spondylosis with myelopathy, cervicothoracic region	ICD-10-CM	Diagnosis
M47.20	Other spondylosis with radiculopathy, site unspecified	ICD-10-CM	Diagnosis
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.22	Other spondylosis with radiculopathy, cervical region	ICD-10-CM	Diagnosis
M47.23	Other spondylosis with radiculopathy, cervicothoracic region	ICD-10-CM	Diagnosis
M47.24	Other spondylosis with radiculopathy, thoracic region	ICD-10-CM	Diagnosis
M47.25	Other spondylosis with radiculopathy, thoracolumbar region	ICD-10-CM	Diagnosis
M47.26	Other spondylosis with radiculopathy, lumbar region	ICD-10-CM	Diagnosis
M47.27	Other spondylosis with radiculopathy, lumbosacral region	ICD-10-CM	Diagnosis
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region	ICD-10-CM	Diagnosis
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region	ICD-10-CM	Diagnosis
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region	ICD-10-CM	Diagnosis
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region	ICD-10-CM	Diagnosis
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region	ICD-10-CM	Diagnosis
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region	ICD-10-CM	Diagnosis
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M47.819	Spondylosis without myelopathy or radiculopathy, site unspecified	ICD-10-CM	Diagnosis
M47.891	Other spondylosis, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.892	Other spondylosis, cervical region	ICD-10-CM	Diagnosis
M47.893	Other spondylosis, cervicothoracic region	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
M47.894	Other spondylosis, thoracic region	ICD-10-CM	Diagnosis
M47.895	Other spondylosis, thoracolumbar region	ICD-10-CM	Diagnosis
M47.896	Other spondylosis, lumbar region	ICD-10-CM	Diagnosis
M47.897	Other spondylosis, lumbosacral region	ICD-10-CM	Diagnosis
M47.898	Other spondylosis, sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M47.899	Other spondylosis, site unspecified	ICD-10-CM	Diagnosis
M47.9	Spondylosis, unspecified	ICD-10-CM	Diagnosis
M48.8X1	Other specified spondylopathies, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M48.8X2	Other specified spondylopathies, cervical region	ICD-10-CM	Diagnosis
M48.8X3	Other specified spondylopathies, cervicothoracic region	ICD-10-CM	Diagnosis
M48.8X4	Other specified spondylopathies, thoracic region	ICD-10-CM	Diagnosis
M48.8X5	Other specified spondylopathies, thoracolumbar region	ICD-10-CM	Diagnosis
M48.8X6	Other specified spondylopathies, lumbar region	ICD-10-CM	Diagnosis
M48.8X7	Other specified spondylopathies, lumbosacral region	ICD-10-CM	Diagnosis
M48.8X8	Other specified spondylopathies, sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M48.8X9	Other specified spondylopathies, site unspecified	ICD-10-CM	Diagnosis
	Stroke		
	Stroke Inclusion Codes		
430	Subarachnoid hemorrhage	ICD-9-CM	Diagnosis
431	Intracerebral hemorrhage	ICD-9-CM	Diagnosis
433.01	Occlusion and stenosis of basilar artery with cerebral infarction	ICD-9-CM	Diagnosis
433.11	Occlusion and stenosis of carotid artery with cerebral infarction	ICD-9-CM	Diagnosis
433.21	Occlusion and stenosis of vertebral artery with cerebral infarction	ICD-9-CM	Diagnosis
433.31	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction	ICD-9-CM	Diagnosis
433.81	Occlusion and stenosis of other specified precerebral artery with cerebral infarction	ICD-9-CM	Diagnosis
433.91	Occlusion and stenosis of unspecified precerebral artery with cerebral infarction	ICD-9-CM	Diagnosis
434.00	Cerebral thrombosis without mention of cerebral infarction	ICD-9-CM	Diagnosis
434.01	Cerebral thrombosis with cerebral infarction	ICD-9-CM	Diagnosis
434.10	Cerebral embolism without mention of cerebral infarction	ICD-9-CM	Diagnosis
434.11	Cerebral embolism with cerebral infarction	ICD-9-CM	Diagnosis
434.90	Unspecified cerebral artery occlusion without mention of cerebral infarction	ICD-9-CM	Diagnosis
434.91	Unspecified cerebral artery occlusion with cerebral infarction	ICD-9-CM	Diagnosis
435.0	Basilar artery syndrome	ICD-9-CM	Diagnosis
435.1	Vertebral artery syndrome	ICD-9-CM	Diagnosis
435.3	Vertebrobasilar artery syndrome	ICD-9-CM	Diagnosis
435.8	Other specified transient cerebral ischemias	ICD-9-CM	Diagnosis
435.9	Unspecified transient cerebral ischemia	ICD-9-CM	Diagnosis
436	Acute, but ill-defined, cerebrovascular disease	ICD-9-CM	Diagnosis
997.02	Iatrogenic cerebrovascular infarction or hemorrhage	ICD-9-CM	Diagnosis
G45.0	Vertebro-basilar artery syndrome	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
G45.1	Carotid artery syndrome (hemispheric)	ICD-10-CM	Diagnosis
G45.2	Multiple and bilateral precerebral artery syndromes	ICD-10-CM	Diagnosis
G45.8	Other transient cerebral ischemic attacks and related syndromes	ICD-10-CM	Diagnosis
G45.9	Transient cerebral ischemic attack, unspecified	ICD-10-CM	Diagnosis
G46.0	Middle cerebral artery syndrome	ICD-10-CM	Diagnosis
G46.1	Anterior cerebral artery syndrome	ICD-10-CM	Diagnosis
G46.2	Posterior cerebral artery syndrome	ICD-10-CM	Diagnosis
G46.3	Brain stem stroke syndrome	ICD-10-CM	Diagnosis
G46.4	Cerebellar stroke syndrome	ICD-10-CM	Diagnosis
G46.5	Pure motor lacunar syndrome	ICD-10-CM	Diagnosis
G46.6	Pure sensory lacunar syndrome	ICD-10-CM	Diagnosis
G46.7	Other lacunar syndromes	ICD-10-CM	Diagnosis
G46.8	Other vascular syndromes of brain in cerebrovascular diseases	ICD-10-CM	Diagnosis
G97.31	Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating a nervous system procedure	ICD-10-CM	Diagnosis
G97.32	Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating other procedure	ICD-10-CM	Diagnosis
I60.00	Nontraumatic subarachnoid hemorrhage from unspecified carotid siphon and	ICD-10-CM	Diagnosis
I60.01	Nontraumatic subarachnoid hemorrhage from right carotid siphon and bifurcation	ICD-10-CM	Diagnosis
I60.02	Nontraumatic subarachnoid hemorrhage from left carotid siphon and bifurcation	ICD-10-CM	Diagnosis
I60.10	Nontraumatic subarachnoid hemorrhage from unspecified middle cerebral artery	ICD-10-CM	Diagnosis
I60.11	Nontraumatic subarachnoid hemorrhage from right middle cerebral artery	ICD-10-CM	Diagnosis
I60.12	Nontraumatic subarachnoid hemorrhage from left middle cerebral artery	ICD-10-CM	Diagnosis
I60.20	Nontraumatic subarachnoid hemorrhage from unspecified anterior communicating artery	ICD-10-CM	Diagnosis
I60.21	Nontraumatic subarachnoid hemorrhage from right anterior communicating artery	ICD-10-CM	Diagnosis
I60.22	Nontraumatic subarachnoid hemorrhage from left anterior communicating artery	ICD-10-CM	Diagnosis
I60.30	Nontraumatic subarachnoid hemorrhage from unspecified posterior communicating artery	ICD-10-CM	Diagnosis
I60.31	Nontraumatic subarachnoid hemorrhage from right posterior communicating artery	ICD-10-CM	Diagnosis
I60.32	Nontraumatic subarachnoid hemorrhage from left posterior communicating artery	ICD-10-CM	Diagnosis
I60.4	Nontraumatic subarachnoid hemorrhage from basilar artery	ICD-10-CM	Diagnosis
I60.50	Nontraumatic subarachnoid hemorrhage from unspecified vertebral artery	ICD-10-CM	Diagnosis
I60.51	Nontraumatic subarachnoid hemorrhage from right vertebral artery	ICD-10-CM	Diagnosis
I60.52	Nontraumatic subarachnoid hemorrhage from left vertebral artery	ICD-10-CM	Diagnosis
I60.6	Nontraumatic subarachnoid hemorrhage from other intracranial arteries	ICD-10-CM	Diagnosis
I60.7	Nontraumatic subarachnoid hemorrhage from unspecified intracranial artery	ICD-10-CM	Diagnosis
I60.8	Other nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I60.9	Nontraumatic subarachnoid hemorrhage, unspecified	ICD-10-CM	Diagnosis
I61.0	Nontraumatic intracerebral hemorrhage in hemisphere, subcortical	ICD-10-CM	Diagnosis
I61.1	Nontraumatic intracerebral hemorrhage in hemisphere, cortical	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I61.2	Nontraumatic intracerebral hemorrhage in hemisphere, unspecified	ICD-10-CM	Diagnosis
I61.3	Nontraumatic intracerebral hemorrhage in brain stem	ICD-10-CM	Diagnosis
I61.4	Nontraumatic intracerebral hemorrhage in cerebellum	ICD-10-CM	Diagnosis
I61.5	Nontraumatic intracerebral hemorrhage, intraventricular	ICD-10-CM	Diagnosis
I61.6	Nontraumatic intracerebral hemorrhage, multiple localized	ICD-10-CM	Diagnosis
I61.8	Other nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I61.9	Nontraumatic intracerebral hemorrhage, unspecified	ICD-10-CM	Diagnosis
I63.00	Cerebral infarction due to thrombosis of unspecified precerebral artery	ICD-10-CM	Diagnosis
I63.011	Cerebral infarction due to thrombosis of right vertebral artery	ICD-10-CM	Diagnosis
I63.012	Cerebral infarction due to thrombosis of left vertebral artery	ICD-10-CM	Diagnosis
I63.013	Cerebral infarction due to thrombosis of bilateral vertebral arteries	ICD-10-CM	Diagnosis
I63.019	Cerebral infarction due to thrombosis of unspecified vertebral artery	ICD-10-CM	Diagnosis
I63.02	Cerebral infarction due to thrombosis of basilar artery	ICD-10-CM	Diagnosis
I63.031	Cerebral infarction due to thrombosis of right carotid artery	ICD-10-CM	Diagnosis
I63.032	Cerebral infarction due to thrombosis of left carotid artery	ICD-10-CM	Diagnosis
I63.039	Cerebral infarction due to thrombosis of unspecified carotid artery	ICD-10-CM	Diagnosis
I63.09	Cerebral infarction due to thrombosis of other precerebral artery	ICD-10-CM	Diagnosis
I63.10	Cerebral infarction due to embolism of unspecified precerebral artery	ICD-10-CM	Diagnosis
I63.111	Cerebral infarction due to embolism of right vertebral artery	ICD-10-CM	Diagnosis
I63.112	Cerebral infarction due to embolism of left vertebral artery	ICD-10-CM	Diagnosis
I63.119	Cerebral infarction due to embolism of unspecified vertebral artery	ICD-10-CM	Diagnosis
I63.12	Cerebral infarction due to embolism of basilar artery	ICD-10-CM	Diagnosis
I63.131	Cerebral infarction due to embolism of right carotid artery	ICD-10-CM	Diagnosis
I63.132	Cerebral infarction due to embolism of left carotid artery	ICD-10-CM	Diagnosis
I63.139	Cerebral infarction due to embolism of unspecified carotid artery	ICD-10-CM	Diagnosis
I63.19	Cerebral infarction due to embolism of other precerebral artery	ICD-10-CM	Diagnosis
I63.20	Cerebral infarction due to unspecified occlusion or stenosis of unspecified precerebral arteries	ICD-10-CM	Diagnosis
I63.211	Cerebral infarction due to unspecified occlusion or stenosis of right vertebral artery	ICD-10-CM	Diagnosis
I63.212	Cerebral infarction due to unspecified occlusion or stenosis of left vertebral artery	ICD-10-CM	Diagnosis
I63.213	Cerebral infarction due to unspecified occlusion or stenosis of bilateral vertebral arteries	ICD-10-CM	Diagnosis
I63.219	Cerebral infarction due to unspecified occlusion or stenosis of unspecified vertebral arteries	ICD-10-CM	Diagnosis
I63.22	Cerebral infarction due to unspecified occlusion or stenosis of basilar artery	ICD-10-CM	Diagnosis
I63.231	Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries	ICD-10-CM	Diagnosis
I63.232	Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries	ICD-10-CM	Diagnosis
I63.233	Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries	ICD-10-CM	Diagnosis
I63.239	Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid	ICD-10-CM	Diagnosis
I63.29	Cerebral infarction due to unspecified occlusion or stenosis of other precerebral arteries	ICD-10-CM	Diagnosis
I63.30	Cerebral infarction due to thrombosis of unspecified cerebral artery	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I63.311	Cerebral infarction due to thrombosis of right middle cerebral artery	ICD-10-CM	Diagnosis
I63.312	Cerebral infarction due to thrombosis of left middle cerebral artery	ICD-10-CM	Diagnosis
I63.313	Cerebral infarction due to thrombosis of bilateral middle cerebral arteries	ICD-10-CM	Diagnosis
I63.319	Cerebral infarction due to thrombosis of unspecified middle cerebral artery	ICD-10-CM	Diagnosis
I63.321	Cerebral infarction due to thrombosis of right anterior cerebral artery	ICD-10-CM	Diagnosis
I63.322	Cerebral infarction due to thrombosis of left anterior cerebral artery	ICD-10-CM	Diagnosis
I63.323	Cerebral infarction due to thrombosis of bilateral anterior cerebral arteries	ICD-10-CM	Diagnosis
I63.329	Cerebral infarction due to thrombosis of unspecified anterior cerebral artery	ICD-10-CM	Diagnosis
I63.331	Cerebral infarction due to thrombosis of right posterior cerebral artery	ICD-10-CM	Diagnosis
I63.332	Cerebral infarction due to thrombosis of left posterior cerebral artery	ICD-10-CM	Diagnosis
I63.333	Cerebral infarction to thrombosis of bilateral posterior cerebral arteries	ICD-10-CM	Diagnosis
I63.339	Cerebral infarction due to thrombosis of unspecified posterior cerebral artery	ICD-10-CM	Diagnosis
I63.341	Cerebral infarction due to thrombosis of right cerebellar artery	ICD-10-CM	Diagnosis
I63.342	Cerebral infarction due to thrombosis of left cerebellar artery	ICD-10-CM	Diagnosis
I63.343	Cerebral infarction to thrombosis of bilateral cerebellar arteries	ICD-10-CM	Diagnosis
I63.349	Cerebral infarction due to thrombosis of unspecified cerebellar artery	ICD-10-CM	Diagnosis
I63.39	Cerebral infarction due to thrombosis of other cerebral artery	ICD-10-CM	Diagnosis
I63.40	Cerebral infarction due to embolism of unspecified cerebral artery	ICD-10-CM	Diagnosis
I63.411	Cerebral infarction due to embolism of right middle cerebral artery	ICD-10-CM	Diagnosis
I63.412	Cerebral infarction due to embolism of left middle cerebral artery	ICD-10-CM	Diagnosis
I63.413	Cerebral infarction due to embolism of bilateral middle cerebral arteries	ICD-10-CM	Diagnosis
I63.419	Cerebral infarction due to embolism of unspecified middle cerebral artery	ICD-10-CM	Diagnosis
I63.421	Cerebral infarction due to embolism of right anterior cerebral artery	ICD-10-CM	Diagnosis
I63.422	Cerebral infarction due to embolism of left anterior cerebral artery	ICD-10-CM	Diagnosis
I63.423	Cerebral infarction due to embolism of bilateral anterior cerebral arteries	ICD-10-CM	Diagnosis
I63.429	Cerebral infarction due to embolism of unspecified anterior cerebral artery	ICD-10-CM	Diagnosis
I63.431	Cerebral infarction due to embolism of right posterior cerebral artery	ICD-10-CM	Diagnosis
I63.432	Cerebral infarction due to embolism of left posterior cerebral artery	ICD-10-CM	Diagnosis
I63.433	Cerebral infarction due to embolism of bilateral posterior cerebral arteries	ICD-10-CM	Diagnosis
I63.439	Cerebral infarction due to embolism of unspecified posterior cerebral artery	ICD-10-CM	Diagnosis
I63.441	Cerebral infarction due to embolism of right cerebellar artery	ICD-10-CM	Diagnosis
I63.442	Cerebral infarction due to embolism of left cerebellar artery	ICD-10-CM	Diagnosis
I63.443	Cerebral infarction due to embolism of bilateral cerebellar arteries	ICD-10-CM	Diagnosis
I63.449	Cerebral infarction due to embolism of unspecified cerebellar artery	ICD-10-CM	Diagnosis
I63.49	Cerebral infarction due to embolism of other cerebral artery	ICD-10-CM	Diagnosis
I63.50	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral	ICD-10-CM	Diagnosis
I63.511	Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery	ICD-10-CM	Diagnosis
I63.512	Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery	ICD-10-CM	Diagnosis
I63.513	Cerebral infarction due to unspecified occlusion or stenosis of bilateral middle cerebral arteries	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I63.519	Cerebral infarction due to unspecified occlusion or stenosis of unspecified middle cerebral artery	ICD-10-CM	Diagnosis
I63.521	Cerebral infarction due to unspecified occlusion or stenosis of right anterior cerebral artery	ICD-10-CM	Diagnosis
I63.522	Cerebral infarction due to unspecified occlusion or stenosis of left anterior cerebral	ICD-10-CM	Diagnosis
I63.523	Cerebral infarction due to unspecified occlusion or stenosis of bilateral anterior cerebral arteries	ICD-10-CM	Diagnosis
I63.529	Cerebral infarction due to unspecified occlusion or stenosis of unspecified anterior cerebral artery	ICD-10-CM	Diagnosis
I63.531	Cerebral infarction due to unspecified occlusion or stenosis of right posterior cerebral artery	ICD-10-CM	Diagnosis
I63.532	Cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery	ICD-10-CM	Diagnosis
I63.533	Cerebral infarction due to unspecified occlusion or stenosis of bilateral posterior cerebral arteries	ICD-10-CM	Diagnosis
I63.539	Cerebral infarction due to unspecified occlusion or stenosis of unspecified posterior cerebral artery	ICD-10-CM	Diagnosis
I63.541	Cerebral infarction due to unspecified occlusion or stenosis of right cerebellar artery	ICD-10-CM	Diagnosis
I63.542	Cerebral infarction due to unspecified occlusion or stenosis of left cerebellar artery	ICD-10-CM	Diagnosis
I63.543	Cerebral infarction due to unspecified occlusion or stenosis of bilateral cerebellar arteries	ICD-10-CM	Diagnosis
I63.549	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery	ICD-10-CM	Diagnosis
I63.59	Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery	ICD-10-CM	Diagnosis
I63.6	Cerebral infarction due to cerebral venous thrombosis, nonpyogenic	ICD-10-CM	Diagnosis
I63.8	Other cerebral infarction	ICD-10-CM	Diagnosis
I63.9	Cerebral infarction, unspecified	ICD-10-CM	Diagnosis
I66.01	Occlusion and stenosis of right middle cerebral artery	ICD-10-CM	Diagnosis
I66.02	Occlusion and stenosis of left middle cerebral artery	ICD-10-CM	Diagnosis
I66.03	Occlusion and stenosis of bilateral middle cerebral arteries	ICD-10-CM	Diagnosis
I66.09	Occlusion and stenosis of unspecified middle cerebral artery	ICD-10-CM	Diagnosis
I66.11	Occlusion and stenosis of right anterior cerebral artery	ICD-10-CM	Diagnosis
I66.12	Occlusion and stenosis of left anterior cerebral artery	ICD-10-CM	Diagnosis
I66.13	Occlusion and stenosis of bilateral anterior cerebral arteries	ICD-10-CM	Diagnosis
I66.19	Occlusion and stenosis of unspecified anterior cerebral artery	ICD-10-CM	Diagnosis
I66.21	Occlusion and stenosis of right posterior cerebral artery	ICD-10-CM	Diagnosis
I66.22	Occlusion and stenosis of left posterior cerebral artery	ICD-10-CM	Diagnosis
I66.23	Occlusion and stenosis of bilateral posterior cerebral arteries	ICD-10-CM	Diagnosis
I66.29	Occlusion and stenosis of unspecified posterior cerebral artery	ICD-10-CM	Diagnosis
I66.3	Occlusion and stenosis of cerebellar arteries	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
I66.8	Occlusion and stenosis of other cerebral arteries	ICD-10-CM	Diagnosis
I66.9	Occlusion and stenosis of unspecified cerebral artery	ICD-10-CM	Diagnosis
I67.841	Reversible cerebrovascular vasoconstriction syndrome	ICD-10-CM	Diagnosis
I67.848	Other cerebrovascular vasospasm and vasoconstriction	ICD-10-CM	Diagnosis
I67.89	Other cerebrovascular disease	ICD-10-CM	Diagnosis
I97.810	Intraoperative cerebrovascular infarction during cardiac surgery	ICD-10-CM	Diagnosis
I97.811	Intraoperative cerebrovascular infarction during other surgery	ICD-10-CM	Diagnosis
I97.820	Postprocedural cerebrovascular infarction following cardiac surgery	ICD-10-CM	Diagnosis
I97.821	Postprocedural cerebrovascular infarction following other surgery	ICD-10-CM	Diagnosis
	Stroke Exclusion Code List 1		
800	Fracture of vault of skull	ICD-9-CM	Diagnosis
800.0	Closed fracture of vault of skull without mention of intracranial injury	ICD-9-CM	Diagnosis
800.00	Closed fracture of vault of skull without mention of intracranial injury, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.01	Closed fracture of vault of skull without mention of intracranial injury, no loss of consciousness	ICD-9-CM	Diagnosis
800.02	Closed fracture of vault of skull without mention of intracranial injury, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.03	Closed fracture of vault of skull without mention of intracranial injury, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
800.04	Closed fracture of vault of skull without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.05	Closed fracture of vault of skull without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.06	Closed fracture of vault of skull without mention of intracranial injury, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.09	Closed fracture of vault of skull without mention of intracranial injury, unspecified concussion	ICD-9-CM	Diagnosis
800.1	Closed fracture of vault of skull with cerebral laceration and contusion	ICD-9-CM	Diagnosis
800.10	Closed fracture of vault of skull with cerebral laceration and contusion, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.11	Closed fracture of vault of skull with cerebral laceration and contusion, no loss of consciousness	ICD-9-CM	Diagnosis
800.12	Closed fracture of vault of skull with cerebral laceration and contusion, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.13	Closed fracture of vault of skull with cerebral laceration and contusion, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
800.14	Closed fracture of vault of skull with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.15	Closed fracture of vault of skull with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.16	Closed fracture of vault of skull with cerebral laceration and contusion, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.19	Closed fracture of vault of skull with cerebral laceration and contusion, unspecified concussion	ICD-9-CM	Diagnosis
800.2	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage	ICD-9-CM	Diagnosis
800.20	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.21	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
800.22	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.23	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
800.24	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.25	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.26	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.29	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
800.3	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage	ICD-9-CM	Diagnosis
800.30	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.31	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
800.32	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.33	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
800.34	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.35	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.36	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.39	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
800.4	Closed fracture of vault of skull with intercranial injury of other and unspecified nature	ICD-9-CM	Diagnosis
800.40	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.41	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, no loss of consciousness	ICD-9-CM	Diagnosis
800.42	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.43	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
800.44	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.45	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.46	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.49	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, unspecified concussion	ICD-9-CM	Diagnosis
800.5	Open fracture of vault of skull without mention of intracranial injury	ICD-9-CM	Diagnosis
800.50	Open fracture of vault of skull without mention of intracranial injury, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.51	Open fracture of vault of skull without mention of intracranial injury, no loss of consciousness	ICD-9-CM	Diagnosis
800.52	Open fracture of vault of skull without mention of intracranial injury, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.53	Open fracture of vault of skull without mention of intracranial injury, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
800.54	Open fracture of vault of skull without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.55	Open fracture of vault of skull without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.56	Open fracture of vault of skull without mention of intracranial injury, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.59	Open fracture of vault of skull without mention of intracranial injury, unspecified concussion	ICD-9-CM	Diagnosis
800.6	Open fracture of vault of skull with cerebral laceration and contusion	ICD-9-CM	Diagnosis
800.60	Open fracture of vault of skull with cerebral laceration and contusion, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.61	Open fracture of vault of skull with cerebral laceration and contusion, no loss of consciousness	ICD-9-CM	Diagnosis
800.62	Open fracture of vault of skull with cerebral laceration and contusion, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.63	Open fracture of vault of skull with cerebral laceration and contusion, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
800.64	Open fracture of vault of skull with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.65	Open fracture of vault of skull with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.66	Open fracture of vault of skull with cerebral laceration and contusion, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.69	Open fracture of vault of skull with cerebral laceration and contusion, unspecified concussion	ICD-9-CM	Diagnosis
800.7	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage	ICD-9-CM	Diagnosis
800.70	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.71	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
800.72	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.73	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
800.74	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.75	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.76	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.79	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
800.8	Open fracture of vault of skull with other and unspecified intracranial hemorrhage	ICD-9-CM	Diagnosis
800.80	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.81	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
800.82	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.83	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
800.84	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.85	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.86	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.89	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
800.9	Open fracture of vault of skull with intracranial injury of other and unspecified nature	ICD-9-CM	Diagnosis
800.90	Open fracture of vault of skull with intracranial injury of other and unspecified nature, unspecified state of consciousness	ICD-9-CM	Diagnosis
800.91	Open fracture of vault of skull with intracranial injury of other and unspecified nature, no loss of consciousness	ICD-9-CM	Diagnosis
800.92	Open fracture of vault of skull with intracranial injury of other and unspecified nature, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
800.93	Open fracture of vault of skull with intracranial injury of other and unspecified nature, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
800.94	Open fracture of vault of skull with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.95	Open fracture of vault of skull with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
800.96	Open fracture of vault of skull with intracranial injury of other and unspecified nature, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
800.99	Open fracture of vault of skull with intracranial injury of other and unspecified nature, unspecified concussion	ICD-9-CM	Diagnosis
801	Fracture of base of skull	ICD-9-CM	Diagnosis
801.0	Closed fracture of base of skull without mention of intracranial injury	ICD-9-CM	Diagnosis
801.00	Closed fracture of base of skull without mention of intracranial injury, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.01	Closed fracture of base of skull without mention of intracranial injury, no loss of consciousness	ICD-9-CM	Diagnosis
801.02	Closed fracture of base of skull without mention of intracranial injury, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.03	Closed fracture of base of skull without mention of intracranial injury, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
801.04	Closed fracture of base of skull without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.05	Closed fracture of base of skull without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.06	Closed fracture of base of skull without mention of intracranial injury, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.09	Closed fracture of base of skull without mention of intracranial injury, unspecified concussion	ICD-9-CM	Diagnosis
801.1	Closed fracture of base of skull with cerebral laceration and contusion	ICD-9-CM	Diagnosis
801.10	Closed fracture of base of skull with cerebral laceration and contusion, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.11	Closed fracture of base of skull with cerebral laceration and contusion, no loss of consciousness	ICD-9-CM	Diagnosis
801.12	Closed fracture of base of skull with cerebral laceration and contusion, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.13	Closed fracture of base of skull with cerebral laceration and contusion, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
801.14	Closed fracture of base of skull with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.15	Closed fracture of base of skull with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.16	Closed fracture of base of skull with cerebral laceration and contusion, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.19	Closed fracture of base of skull with cerebral laceration and contusion, unspecified concussion	ICD-9-CM	Diagnosis
801.2	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage	ICD-9-CM	Diagnosis
801.20	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.21	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
801.22	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.23	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
801.24	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.25	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.26	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.29	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
801.3	Closed fracture of base of skull with other and unspecified intracranial hemorrhage	ICD-9-CM	Diagnosis
801.30	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.31	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
801.32	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.33	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
801.34	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.35	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.36	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.39	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
801.4	Closed fracture of base of skull with intracranial injury of other and unspecified nature	ICD-9-CM	Diagnosis
801.40	Closed fracture of base of skull with intracranial injury of other and unspecified nature, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.41	Closed fracture of base of skull with intracranial injury of other and unspecified nature, no loss of consciousness	ICD-9-CM	Diagnosis
801.42	Closed fracture of base of skull with intracranial injury of other and unspecified nature, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.43	Closed fracture of base of skull with intracranial injury of other and unspecified nature, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
801.44	Closed fracture of base of skull with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.45	Closed fracture of base of skull with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.46	Closed fracture of base of skull with intracranial injury of other and unspecified nature, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.49	Closed fracture of base of skull with intracranial injury of other and unspecified nature, unspecified concussion	ICD-9-CM	Diagnosis
801.5	Open fracture of base of skull without mention of intracranial injury	ICD-9-CM	Diagnosis
801.50	Open fracture of base of skull without mention of intracranial injury, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.51	Open fracture of base of skull without mention of intracranial injury, no loss of consciousness	ICD-9-CM	Diagnosis
801.52	Open fracture of base of skull without mention of intracranial injury, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.53	Open fracture of base of skull without mention of intracranial injury, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
801.54	Open fracture of base of skull without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.55	Open fracture of base of skull without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.56	Open fracture of base of skull without mention of intracranial injury, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.59	Open fracture of base of skull without mention of intracranial injury, unspecified concussion	ICD-9-CM	Diagnosis
801.6	Open fracture of base of skull with cerebral laceration and contusion	ICD-9-CM	Diagnosis
801.60	Open fracture of base of skull with cerebral laceration and contusion, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.61	Open fracture of base of skull with cerebral laceration and contusion, no loss of consciousness	ICD-9-CM	Diagnosis
801.62	Open fracture of base of skull with cerebral laceration and contusion, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.63	Open fracture of base of skull with cerebral laceration and contusion, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
801.64	Open fracture of base of skull with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.65	Open fracture of base of skull with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.66	Open fracture of base of skull with cerebral laceration and contusion, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.69	Open fracture of base of skull with cerebral laceration and contusion, unspecified concussion	ICD-9-CM	Diagnosis
801.7	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage	ICD-9-CM	Diagnosis
801.70	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.71	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
801.72	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.73	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
801.74	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.75	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.76	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.79	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
801.8	Open fracture of base of skull with other and unspecified intracranial hemorrhage	ICD-9-CM	Diagnosis
801.80	Open fracture of base of skull with other and unspecified intracranial hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.81	Open fracture of base of skull with other and unspecified intracranial hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
801.82	Open fracture of base of skull with other and unspecified intracranial hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.83	Open fracture of base of skull with other and unspecified intracranial hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
801.84	Open fracture of base of skull with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.85	Open fracture of base of skull with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.86	Open fracture of base of skull with other and unspecified intracranial hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.89	Open fracture of base of skull with other and unspecified intracranial hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
801.9	Open fracture of base of skull with intracranial injury of other and unspecified nature	ICD-9-CM	Diagnosis
801.90	Open fracture of base of skull with intracranial injury of other and unspecified nature, unspecified state of consciousness	ICD-9-CM	Diagnosis
801.91	Open fracture of base of skull with intracranial injury of other and unspecified nature, no loss of consciousness	ICD-9-CM	Diagnosis
801.92	Open fracture of base of skull with intracranial injury of other and unspecified nature, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
801.93	Open fracture of base of skull with intracranial injury of other and unspecified nature, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
801.94	Open fracture of base of skull with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.95	Open fracture of base of skull with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
801.96	Open fracture of base of skull with intracranial injury of other and unspecified nature, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
801.99	Open fracture of base of skull with intracranial injury of other and unspecified nature, unspecified concussion	ICD-9-CM	Diagnosis
802	Fracture of face bones	ICD-9-CM	Diagnosis
802.0	Nasal bones, closed fracture	ICD-9-CM	Diagnosis
802.1	Nasal bones, open fracture	ICD-9-CM	Diagnosis
802.2	Mandible, closed fracture	ICD-9-CM	Diagnosis
802.20	Closed fracture of unspecified site of mandible	ICD-9-CM	Diagnosis
802.21	Closed fracture of condylar process of mandible	ICD-9-CM	Diagnosis
802.22	Closed fracture of subcondylar process of mandible	ICD-9-CM	Diagnosis
802.23	Closed fracture of coronoid process of mandible	ICD-9-CM	Diagnosis
802.24	Closed fracture of unspecified part of ramus of mandible	ICD-9-CM	Diagnosis
802.25	Closed fracture of angle of jaw	ICD-9-CM	Diagnosis
802.26	Closed fracture of symphysis of body of mandible	ICD-9-CM	Diagnosis
802.27	Closed fracture of alveolar border of body of mandible	ICD-9-CM	Diagnosis
802.28	Closed fracture of other and unspecified part of body of mandible	ICD-9-CM	Diagnosis
802.29	Closed fracture of multiple sites of mandible	ICD-9-CM	Diagnosis
802.3	Mandible, open fracture	ICD-9-CM	Diagnosis
802.30	Open fracture of unspecified site of mandible	ICD-9-CM	Diagnosis
802.31	Open fracture of condylar process of mandible	ICD-9-CM	Diagnosis
802.32	Open fracture of subcondylar process of mandible	ICD-9-CM	Diagnosis
802.33	Open fracture of coronoid process of mandible	ICD-9-CM	Diagnosis
802.34	Open fracture of unspecified part of ramus of mandible	ICD-9-CM	Diagnosis
802.35	Open fracture of angle of jaw	ICD-9-CM	Diagnosis
802.36	Open fracture of symphysis of body of mandible	ICD-9-CM	Diagnosis
802.37	Open fracture of alveolar border of body of mandible	ICD-9-CM	Diagnosis
802.38	Open fracture of other and unspecified part of body of mandible	ICD-9-CM	Diagnosis
802.39	Open fracture of multiple sites of mandible	ICD-9-CM	Diagnosis
802.4	Malar and maxillary bones, closed fracture	ICD-9-CM	Diagnosis
802.5	Malar and maxillary bones, open fracture	ICD-9-CM	Diagnosis
802.6	Orbital floor (blow-out), closed fracture	ICD-9-CM	Diagnosis
802.7	Orbital floor (blow-out), open fracture	ICD-9-CM	Diagnosis
802.8	Other facial bones, closed fracture	ICD-9-CM	Diagnosis
802.9	Other facial bones, open fracture	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
803	Other and unqualified skull fractures	ICD-9-CM	Diagnosis
803.0	Other closed skull fracture without mention of intracranial injury	ICD-9-CM	Diagnosis
803.00	Other closed skull fracture without mention of intracranial injury, unspecified state of consciousness	ICD-9-CM	Diagnosis
803.01	Other closed skull fracture without mention of intracranial injury, no loss of consciousness	ICD-9-CM	Diagnosis
803.02	Other closed skull fracture without mention of intracranial injury, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
803.03	Other closed skull fracture without mention of intracranial injury, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
803.04	Other closed skull fracture without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.05	Other closed skull fracture without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.06	Other closed skull fracture without mention of intracranial injury, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.09	Other closed skull fracture without mention of intracranial injury, unspecified concussion	ICD-9-CM	Diagnosis
803.1	Other closed skull fracture with cerebral laceration and contusion	ICD-9-CM	Diagnosis
803.10	Other closed skull fracture with cerebral laceration and contusion, unspecified state of consciousness	ICD-9-CM	Diagnosis
803.11	Other closed skull fracture with cerebral laceration and contusion, no loss of consciousness	ICD-9-CM	Diagnosis
803.12	Other closed skull fracture with cerebral laceration and contusion, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
803.13	Other closed skull fracture with cerebral laceration and contusion, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
803.14	Other closed skull fracture with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.15	Other closed skull fracture with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.16	Other closed skull fracture with cerebral laceration and contusion, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.19	Other closed skull fracture with cerebral laceration and contusion, unspecified concussion	ICD-9-CM	Diagnosis
803.2	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
803.20	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
803.21	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
803.22	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
803.23	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
803.24	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.25	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.26	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.29	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
803.3	Closed skull fracture with other and unspecified intracranial hemorrhage	ICD-9-CM	Diagnosis
803.30	Other closed skull fracture with other and unspecified intracranial hemorrhage, unspecified state of unconsciousness	ICD-9-CM	Diagnosis
803.31	Other closed skull fracture with other and unspecified intracranial hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
803.32	Other closed skull fracture with other and unspecified intracranial hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
803.33	Other closed skull fracture with other and unspecified intracranial hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
803.34	Other closed skull fracture with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.35	Other closed skull fracture with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.36	Other closed skull fracture with other and unspecified intracranial hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.39	Other closed skull fracture with other and unspecified intracranial hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
803.4	Other closed skull fracture with intracranial injury of other and unspecified nature	ICD-9-CM	Diagnosis
803.40	Other closed skull fracture with intracranial injury of other and unspecified nature, unspecified state of consciousness	ICD-9-CM	Diagnosis

Code	Description	Code Type	Code Category
803.41	Other closed skull fracture with intracranial injury of other and unspecified nature, no loss of consciousness	ICD-9-CM	Diagnosis
803.42	Other closed skull fracture with intracranial injury of other and unspecified nature, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
803.43	Other closed skull fracture with intracranial injury of other and unspecified nature, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
803.44	Other closed skull fracture with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.45	Other closed skull fracture with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.46	Other closed skull fracture with intracranial injury of other and unspecified nature, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.49	Other closed skull fracture with intracranial injury of other and unspecified nature, unspecified concussion	ICD-9-CM	Diagnosis
803.50	Other open skull fracture without mention of injury, state of consciousness unspecified	ICD-9-CM	Diagnosis
803.5	Other open skull fracture without mention of intracranial injury	ICD-9-CM	Diagnosis
803.51	Other open skull fracture without mention of intracranial injury, no loss of consciousness	ICD-9-CM	Diagnosis
803.52	Other open skull fracture without mention of intracranial injury, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
803.53	Other open skull fracture without mention of intracranial injury, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
803.54	Other open skull fracture without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.55	Other open skull fracture without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.56	Other open skull fracture without mention of intracranial injury, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.59	Other open skull fracture without mention of intracranial injury, unspecified concussion	ICD-9-CM	Diagnosis
803.6	Other open skull fracture with cerebral laceration and contusion	ICD-9-CM	Diagnosis
803.60	Other open skull fracture with cerebral laceration and contusion, unspecified state of consciousness	ICD-9-CM	Diagnosis
803.61	Other open skull fracture with cerebral laceration and contusion, no loss of consciousness	ICD-9-CM	Diagnosis
803.62	Other open skull fracture with cerebral laceration and contusion, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
803.63	Other open skull fracture with cerebral laceration and contusion, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
803.64	Other open skull fracture with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.65	Other open skull fracture with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.66	Other open skull fracture with cerebral laceration and contusion, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.69	Other open skull fracture with cerebral laceration and contusion, unspecified concussion	ICD-9-CM	Diagnosis
803.7	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage	ICD-9-CM	Diagnosis
803.70	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
803.71	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
803.72	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
803.73	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
803.74	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.75	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.76	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.79	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
803.8	Other open skull fracture with other and unspecified intracranial hemorrhage	ICD-9-CM	Diagnosis
803.80	Other open skull fracture with other and unspecified intracranial hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
803.81	Other open skull fracture with other and unspecified intracranial hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
803.82	Other open skull fracture with other and unspecified intracranial hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
803.83	Other open skull fracture with other and unspecified intracranial hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
803.84	Other open skull fracture with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.85	Other open skull fracture with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.86	Other open skull fracture with other and unspecified intracranial hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.89	Other open skull fracture with other and unspecified intracranial hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
803.9	Other open skull fracture with intracranial injury of other and unspecified nature	ICD-9-CM	Diagnosis
803.90	Other open skull fracture with intracranial injury of other and unspecified nature, unspecified state of consciousness	ICD-9-CM	Diagnosis
803.91	Other open skull fracture with intracranial injury of other and unspecified nature, no loss of consciousness	ICD-9-CM	Diagnosis
803.92	Other open skull fracture with intracranial injury of other and unspecified nature, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
803.93	Other open skull fracture with intracranial injury of other and unspecified nature, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
803.94	Other open skull fracture with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.95	Other open skull fracture with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
803.96	Other open skull fracture with intracranial injury of other and unspecified nature, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
803.99	Other open skull fracture with intracranial injury of other and unspecified nature, unspecified concussion	ICD-9-CM	Diagnosis
804.0	Closed fractures involving skull or face with other bones, without mention of intracranial injury	ICD-9-CM	Diagnosis
804.00	Closed fractures involving skull or face with other bones, without mention of intracranial injury, unspecified state of consciousness	ICD-9-CM	Diagnosis
804	Multiple fractures involving skull or face with other bones	ICD-9-CM	Diagnosis
804.01	Closed fractures involving skull or face with other bones, without mention of intracranial injury, no loss of consciousness	ICD-9-CM	Diagnosis
804.02	Closed fractures involving skull or face with other bones, without mention of intracranial injury, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
804.03	Closed fractures involving skull or face with other bones, without mention of intracranial injury, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
804.04	Closed fractures involving skull or face with other bones, without mention or intracranial injury, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.05	Closed fractures involving skull of face with other bones, without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.06	Closed fractures involving skull of face with other bones, without mention of intracranial injury, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.09	Closed fractures involving skull of face with other bones, without mention of intracranial injury, unspecified concussion	ICD-9-CM	Diagnosis
804.1	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion	ICD-9-CM	Diagnosis
804.10	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, unspecified state of consciousness	ICD-9-CM	Diagnosis
804.11	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, no loss of consciousness	ICD-9-CM	Diagnosis
804.12	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
804.13	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
804.14	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.15	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.16	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.19	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, unspecified concussion	ICD-9-CM	Diagnosis
804.2	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage	ICD-9-CM	Diagnosis
804.20	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
804.21	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
804.22	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
804.23	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
804.24	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.25	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.26	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.29	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
804.3	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage	ICD-9-CM	Diagnosis
804.30	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
804.31	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
804.32	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
804.33	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
804.34	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to preexisting conscious level	ICD-9-CM	Diagnosis
804.35	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.36	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.39	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
804.4	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature	ICD-9-CM	Diagnosis
804.40	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, unspecified state of consciousness	ICD-9-CM	Diagnosis
804.41	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, no loss of consciousness	ICD-9-CM	Diagnosis
804.42	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
804.43	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
804.44	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.45	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.46	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.49	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, unspecified concussion	ICD-9-CM	Diagnosis
804.5	Open fractures involving skull or face with other bones, without mention of intracranial injury	ICD-9-CM	Diagnosis
804.50	Open fractures involving skull or face with other bones, without mention of intracranial injury, unspecified state of consciousness	ICD-9-CM	Diagnosis
804.51	Open fractures involving skull or face with other bones, without mention of intracranial injury, no loss of consciousness	ICD-9-CM	Diagnosis
804.52	Open fractures involving skull or face with other bones, without mention of intracranial injury, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
804.53	Open fractures involving skull or face with other bones, without mention of intracranial injury, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
804.54	Open fractures involving skull or face with other bones, without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.55	Open fractures involving skull or face with other bones, without mention of intracranial injury, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.56	Open fractures involving skull or face with other bones, without mention of intracranial injury, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.59	Open fractures involving skull or face with other bones, without mention of intracranial injury, unspecified concussion	ICD-9-CM	Diagnosis
804.6	Open fractures involving skull or face with other bones, with cerebral laceration and contusion	ICD-9-CM	Diagnosis
804.60	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, unspecified state of consciousness	ICD-9-CM	Diagnosis
804.61	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, no loss of consciousness	ICD-9-CM	Diagnosis
804.62	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
804.63	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
804.64	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.65	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.66	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.69	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, unspecified concussion	ICD-9-CM	Diagnosis
804.7	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage	ICD-9-CM	Diagnosis
804.70	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
804.71	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis
804.72	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
804.73	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
804.74	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.75	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.76	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.79	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
804.8	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage	ICD-9-CM	Diagnosis
804.80	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, unspecified state of consciousness	ICD-9-CM	Diagnosis
804.81	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, no loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
804.82	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
804.83	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
804.84	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.85	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.86	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.89	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, unspecified concussion	ICD-9-CM	Diagnosis
804.9	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature	ICD-9-CM	Diagnosis
804.90	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, unspecified state of consciousness	ICD-9-CM	Diagnosis
804.91	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, no loss of consciousness	ICD-9-CM	Diagnosis
804.92	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
804.93	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
804.94	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
804.95	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing level	ICD-9-CM	Diagnosis
804.96	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
804.99	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, unspecified concussion	ICD-9-CM	Diagnosis
850	Concussion	ICD-9-CM	Diagnosis
850.0	Concussion with no loss of consciousness	ICD-9-CM	Diagnosis
850.1	Concussion with brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
850.11	Concussion, with loss of consciousness of 30 minutes or less	ICD-9-CM	Diagnosis
850.12	Concussion, with loss of consciousness 31 to 59 minutes	ICD-9-CM	Diagnosis
850.2	Concussion with moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
850.3	Concussion with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
850.4	Concussion with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
850.5	Concussion with loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
850.9	Unspecified concussion	ICD-9-CM	Diagnosis
851	Cerebral laceration and contusion	ICD-9-CM	Diagnosis
851.0	Cortex (cerebral) contusion without mention of open intracranial wound	ICD-9-CM	Diagnosis
851.00	Cortex (cerebral) contusion without mention of open intracranial wound, state of consciousness unspecified	ICD-9-CM	Diagnosis
851.01	Cortex (cerebral) contusion without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.02	Cortex (cerebral) contusion without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
851.03	Cortex (cerebral) contusion without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.04	Cortex (cerebral) contusion without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.05	Cortex (cerebral) contusion without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.06	Cortex (cerebral) contusion without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.09	Cortex (cerebral) contusion without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
851.1	Cortex (cerebral) contusion with open intracranial wound	ICD-9-CM	Diagnosis
851.10	Cortex (cerebral) contusion with open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
851.11	Cortex (cerebral) contusion with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.12	Cortex (cerebral) contusion with open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
851.13	Cortex (cerebral) contusion with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.14	Cortex (cerebral) contusion with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.15	Cortex (cerebral) contusion with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.16	Cortex (cerebral) contusion with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.19	Cortex (cerebral) contusion with open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
851.2	Cortex (cerebral) laceration without mention of open intracranial wound	ICD-9-CM	Diagnosis
851.20	Cortex (cerebral) laceration without mention of open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
851.21	Cortex (cerebral) laceration without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.22	Cortex (cerebral) laceration without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
851.23	Cortex (cerebral) laceration without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.24	Cortex (cerebral) laceration without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.25	Cortex (cerebral) laceration without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.26	Cortex (cerebral) laceration without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.29	Cortex (cerebral) laceration without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
851.3	Cortex (cerebral) laceration with open intracranial wound	ICD-9-CM	Diagnosis
851.30	Cortex (cerebral) laceration with open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
851.31	Cortex (cerebral) laceration with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.32	Cortex (cerebral) laceration with open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
851.33	Cortex (cerebral) laceration with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.34	Cortex (cerebral) laceration with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.35	Cortex (cerebral) laceration with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.36	Cortex (cerebral) laceration with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.39	Cortex (cerebral) laceration with open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
851.4	Cerebellar or brain stem contusion without mention of open intracranial wound	ICD-9-CM	Diagnosis
851.40	Cerebellar or brain stem contusion without mention of open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
851.41	Cerebellar or brain stem contusion without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.42	Cerebellar or brain stem contusion without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
851.43	Cerebellar or brain stem contusion without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.44	Cerebellar or brain stem contusion without mention of open intracranial wound, prolonged (more than 24 hours) loss consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.45	Cerebellar or brain stem contusion without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.46	Cerebellar or brain stem contusion without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.49	Cerebellar or brain stem contusion without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
851.5	Cerebellar or brain stem contusion with open intracranial wound	ICD-9-CM	Diagnosis
851.50	Cerebellar or brain stem contusion with open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
851.51	Cerebellar or brain stem contusion with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.52	Cerebellar or brain stem contusion with open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
851.53	Cerebellar or brain stem contusion with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.54	Cerebellar or brain stem contusion with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.55	Cerebellar or brain stem contusion with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.56	Cerebellar or brain stem contusion with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.59	Cerebellar or brain stem contusion with open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
851.6	Cerebellar or brain stem laceration without mention of open intracranial wound	ICD-9-CM	Diagnosis
851.60	Cerebellar or brain stem laceration without mention of open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
851.61	Cerebellar or brain stem laceration without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.62	Cerebellar or brain stem laceration without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
851.63	Cerebellar or brain stem laceration without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.64	Cerebellar or brain stem laceration without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
851.65	Cerebellar or brain stem laceration without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.66	Cerebellar or brain stem laceration without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.69	Cerebellar or brain stem laceration without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
851.7	Cerebellar or brain stem laceration with open intracranial wound	ICD-9-CM	Diagnosis
851.70	Cerebellar or brain stem laceration with open intracranial wound, state of consciousness unspecified	ICD-9-CM	Diagnosis
851.71	Cerebellar or brain stem laceration with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.72	Cerebellar or brain stem laceration with open intracranial wound, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
851.73	Cerebellar or brain stem laceration with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.74	Cerebellar or brain stem laceration with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.75	Cerebellar or brain stem laceration with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.76	Cerebellar or brain stem laceration with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.79	Cerebellar or brain stem laceration with open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
851.8	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound	ICD-9-CM	Diagnosis
851.80	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
851.81	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.82	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
851.83	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.84	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to preexisting conscious level	ICD-9-CM	Diagnosis
851.85	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
851.86	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.89	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
851.9	Other and unspecified cerebral laceration and contusion, with open intracranial wound	ICD-9-CM	Diagnosis
851.90	Other and unspecified cerebral laceration and contusion, with open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
851.91	Other and unspecified cerebral laceration and contusion, with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
851.92	Other and unspecified cerebral laceration and contusion, with open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
851.93	Other and unspecified cerebral laceration and contusion, with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
851.94	Other and unspecified cerebral laceration and contusion, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.95	Other and unspecified cerebral laceration and contusion, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
851.96	Other and unspecified cerebral laceration and contusion, with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
851.99	Other and unspecified cerebral laceration and contusion, with open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
852.0	Subarachnoid hemorrhage following injury without mention of open intracranial wound	ICD-9-CM	Diagnosis
852.00	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
852	Subarachnoid, subdural, and extradural hemorrhage, following injury	ICD-9-CM	Diagnosis
852.01	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
852.02	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
852.03	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
852.04	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.05	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
852.06	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
852.09	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
852.1	Subarachnoid hemorrhage following injury, with open intracranial wound	ICD-9-CM	Diagnosis
852.10	Subarachnoid hemorrhage following injury, with open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
852.11	Subarachnoid hemorrhage following injury, with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
852.12	Subarachnoid hemorrhage following injury, with open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
852.13	Subarachnoid hemorrhage following injury, with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
852.14	Subarachnoid hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.15	Subarachnoid hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.16	Subarachnoid hemorrhage following injury, with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
852.19	Subarachnoid hemorrhage following injury, with open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
852.2	Subdural hemorrhage following injury without mention of open intracranial wound	ICD-9-CM	Diagnosis
852.20	Subdural hemorrhage following injury, without mention of open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
852.21	Subdural hemorrhage following injury, without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
852.22	Subdural hemorrhage following injury, without mention of open intracranial wound, brief (less than one hour) loss of consciousness	ICD-9-CM	Diagnosis
852.23	Subdural hemorrhage following injury, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
852.24	Subdural hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.25	Subdural hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.26	Subdural hemorrhage following injury, without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis

Code	Description	Code Type	Code Category
852.29	Subdural hemorrhage following injury, without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
852.3	Subdural hemorrhage following injury, with open intracranial wound	ICD-9-CM	Diagnosis
852.30	Subdural hemorrhage following injury, with open intracranial wound, state of consciousness unspecified	ICD-9-CM	Diagnosis
852.31	Subdural hemorrhage following injury, with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
852.32	Subdural hemorrhage following injury, with open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
852.33	Subdural hemorrhage following injury, with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
852.34	Subdural hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.35	Subdural hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.36	Subdural hemorrhage following injury, with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
852.39	Subdural hemorrhage following injury, with open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
852.4	Extradural hemorrhage following injury without mention of open intracranial wound	ICD-9-CM	Diagnosis
852.40	Extradural hemorrhage following injury, without mention of open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
852.41	Extradural hemorrhage following injury, without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
852.42	Extradural hemorrhage following injury, without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
852.43	Extradural hemorrhage following injury, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
852.44	Extradural hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.45	Extradural hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.46	Extradural hemorrhage following injury, without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
852.49	Extradural hemorrhage following injury, without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
852.5	Extradural hemorrhage following injury with open intracranial wound	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
852.50	Extradural hemorrhage following injury, with open intracranial wound, state of consciousness unspecified	ICD-9-CM	Diagnosis
852.51	Extradural hemorrhage following injury, with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
852.52	Extradural hemorrhage following injury, with open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
852.53	Extradural hemorrhage following injury, with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
852.54	Extradural hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.55	Extradural hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
852.56	Extradural hemorrhage following injury, with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
852.59	Extradural hemorrhage following injury, with open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
853	Other and unspecified intracranial hemorrhage following injury	ICD-9-CM	Diagnosis
853.0	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound	ICD-9-CM	Diagnosis
853.00	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
853.01	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
853.02	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
853.03	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
853.04	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to preexisting conscious level	ICD-9-CM	Diagnosis
853.05	Other and unspecified intracranial hemorrhage following injury. Without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
853.06	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
853.09	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
853.1	Other and unspecified intracranial hemorrhage following injury with open intracranial wound	ICD-9-CM	Diagnosis
853.10	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
853.11	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
853.12	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
853.13	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
853.14	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
853.15	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
853.16	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
853.19	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis
854	Intracranial injury of other and unspecified nature	ICD-9-CM	Diagnosis
854.0	Intracranial injury of other and unspecified nature without mention of open intracranial wound	ICD-9-CM	Diagnosis
854.00	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
854.01	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
854.02	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
854.03	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
854.04	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
854.05	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
854.06	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
854.09	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, unspecified concussion	ICD-9-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
854.1	Intracranial injury of other and unspecified nature with open intracranial wound	ICD-9-CM	Diagnosis
854.10	Intracranial injury of other and unspecified nature, with open intracranial wound, unspecified state of consciousness	ICD-9-CM	Diagnosis
854.11	Intracranial injury of other and unspecified nature, with open intracranial wound, no loss of consciousness	ICD-9-CM	Diagnosis
854.12	Intracranial injury of other and unspecified nature, with open intracranial wound, brief (less than 1 hour) loss of consciousness	ICD-9-CM	Diagnosis
854.13	Intracranial injury of other and unspecified nature, with open intracranial wound, moderate (1-24 hours) loss of consciousness	ICD-9-CM	Diagnosis
854.14	Intracranial injury of other and unspecified nature, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level	ICD-9-CM	Diagnosis
854.15	Intracranial injury of other and unspecified nature, with open intracranial wound, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level	ICD-9-CM	Diagnosis
854.16	Intracranial injury of other and unspecified nature, with open intracranial wound, loss of consciousness of unspecified duration	ICD-9-CM	Diagnosis
854.19	Intracranial injury of other and unspecified nature, with open intracranial wound, with unspecified concussion	ICD-9-CM	Diagnosis
S01.90XA	Unspecified open wound of unspecified part of head, initial encounter	ICD-10-CM	Diagnosis
S02.0XXA	Fracture of vault of skull, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.0XXB	Fracture of vault of skull, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.101A	Fracture of base of skull, right side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.101B	Fracture of base of skull, right side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.102A	Fracture of base of skull, left side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.102B	Fracture of base of skull, left side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.109A	Fracture of base of skull, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.109B	Fracture of base of skull, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.10XA	Unspecified fracture of base of skull, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.10XB	Unspecified fracture of base of skull, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.110A	Type I occipital condyle fracture, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.110B	Type I occipital condyle fracture, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.111A	Type II occipital condyle fracture, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.111B	Type II occipital condyle fracture, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.112A	Type III occipital condyle fracture, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.112B	Type III occipital condyle fracture, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.113A	Unspecified occipital condyle fracture, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.113B	Unspecified occipital condyle fracture, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.118A	Other fracture of occiput, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S02.118B	Other fracture of occiput, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.119A	Unspecified fracture of occiput, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.119B	Unspecified fracture of occiput, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.11GA	Other fracture of occiput, right side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.11GB	Other fracture of occiput, right side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.11HA	Other fracture of occiput, left side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.11HB	Other fracture of occiput, left side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.19XA	Other fracture of base of skull, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.19XB	Other fracture of base of skull, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.2XXA	Fracture of nasal bones, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.2XXB	Fracture of nasal bones, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.30XA	Fracture of orbital floor, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.30XB	Fracture of orbital floor, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.31XA	Fracture of orbital floor, right side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.31XB	Fracture of orbital floor, right side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.32XA	Fracture of orbital floor, left side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.32XB	Fracture of orbital floor, left side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.3XXA	Fracture of orbital floor, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.3XXB	Fracture of orbital floor, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.400A	Malar fracture, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.400B	Malar fracture, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.401A	Maxillary fracture, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.401B	Maxillary fracture, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.402A	Zygomatic fracture, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.402B	Zygomatic fracture, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.40AA	Malar fracture, right side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.40AB	Malar fracture, right side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.40BA	Malar fracture, left side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.40BB	Malar fracture, left side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.40CA	Maxillary fracture, right side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.40CB	Maxillary fracture, right side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.40DA	Maxillary fracture, left side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.40DB	Maxillary fracture, left side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.40EA	Zygomatic fracture, right side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.40EB	Zygomatic fracture, right side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.40FA	Zygomatic fracture, left side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.40FB	Zygomatic fracture, left side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.411A	LeFort I fracture, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.411B	LeFort I fracture, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.412A	LeFort II fracture, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.412B	LeFort II fracture, initial encounter for open fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S02.413A	LeFort III fracture, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.413B	LeFort III fracture, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.42XA	Fracture of alveolus of maxilla, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.42XB	Fracture of alveolus of maxilla, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.600A	Fracture of unspecified part of body of mandible, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.600B	Fracture of unspecified part of body of mandible, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.601A	Fracture of unspecified part of body of right mandible, initial encounter for closed	ICD-10-CM	Diagnosis
S02.601B	Fracture of unspecified part of body of right mandible, initial encounter for open	ICD-10-CM	Diagnosis
S02.602A	Fracture of unspecified part of body of left mandible, initial encounter for closed	ICD-10-CM	Diagnosis
S02.602B	Fracture of unspecified part of body of left mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.609A	Fracture of mandible, unspecified, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.609B	Fracture of mandible, unspecified, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.610A	Fracture of condylar process of mandible, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.610B	Fracture of condylar process of mandible, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.611A	Fracture of condylar process of right mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.611B	Fracture of condylar process of right mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.612A	Fracture of condylar process of left mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.612B	Fracture of condylar process of left mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.61XA	Fracture of condylar process of mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.61XB	Fracture of condylar process of mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.620A	Fracture of subcondylar process of mandible, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.620B	Fracture of subcondylar process of mandible, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.621A	Fracture of subcondylar process of right mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.621B	Fracture of subcondylar process of right mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.622A	Fracture of subcondylar process of left mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.622B	Fracture of subcondylar process of left mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.62XA	Fracture of subcondylar process of mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.62XB	Fracture of subcondylar process of mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.630A	Fracture of coronoid process of mandible, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S02.630B	Fracture of coronoid process of mandible, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.631A	Fracture of coronoid process of right mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.631B	Fracture of coronoid process of right mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.632A	Fracture of coronoid process of left mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.632B	Fracture of coronoid process of left mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.63XA	Fracture of coronoid process of mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.63XB	Fracture of coronoid process of mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.640A	Fracture of ramus of mandible, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.640B	Fracture of ramus of mandible, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.641A	Fracture of ramus of right mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.641B	Fracture of ramus of right mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.642A	Fracture of ramus of left mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.642B	Fracture of ramus of left mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.64XA	Fracture of ramus of mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.64XB	Fracture of ramus of mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.650A	Fracture of angle of mandible, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.650B	Fracture of angle of mandible, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.651A	Fracture of angle of right mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.651B	Fracture of angle of right mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.652A	Fracture of angle of left mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.652B	Fracture of angle of left mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.65XA	Fracture of angle of mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.65XB	Fracture of angle of mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.66XA	Fracture of symphysis of mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.66XB	Fracture of symphysis of mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.670A	Fracture of alveolus of mandible, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.670B	Fracture of alveolus of mandible, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.671A	Fracture of alveolus of right mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.671B	Fracture of alveolus of right mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.672A	Fracture of alveolus of left mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.672B	Fracture of alveolus of left mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.67XA	Fracture of alveolus of mandible, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.67XB	Fracture of alveolus of mandible, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.69XA	Fracture of mandible of other specified site, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.69XB	Fracture of mandible of other specified site, initial encounter for open fracture	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S02.80XA	Fracture of other specified skull and facial bones, unspecified side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.80XB	Fracture of other specified skull and facial bones, unspecified side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.81XA	Fracture of other specified skull and facial bones, right side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.81XB	Fracture of other specified skull and facial bones, right side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.82XA	Fracture of other specified skull and facial bones, left side, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.82XB	Fracture of other specified skull and facial bones, left side, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.8XXA	Fractures of other specified skull and facial bones, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.8XXB	Fractures of other specified skull and facial bones, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.91XA	Unspecified fracture of skull, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.91XB	Unspecified fracture of skull, initial encounter for open fracture	ICD-10-CM	Diagnosis
S02.92XA	Unspecified fracture of facial bones, initial encounter for closed fracture	ICD-10-CM	Diagnosis
S02.92XB	Unspecified fracture of facial bones, initial encounter for open fracture	ICD-10-CM	Diagnosis
S06.0X0A	Concussion without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.0X1A	Concussion with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.0X2A	Concussion with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.0X3A	Concussion with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.0X4A	Concussion with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.0X5A	Concussion with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.0X6A	Concussion with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.0X7A	Concussion with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.0X8A	Concussion with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.0X9A	Concussion with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.1X0A	Traumatic cerebral edema without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.1X1A	Traumatic cerebral edema with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.1X2A	Traumatic cerebral edema with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S06.1X3A	Traumatic cerebral edema with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.1X4A	Traumatic cerebral edema with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.1X5A	Traumatic cerebral edema with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.1X6A	Traumatic cerebral edema with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.1X7A	Traumatic cerebral edema with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.1X8A	Traumatic cerebral edema with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.1X9A	Traumatic cerebral edema with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.2X0A	Diffuse traumatic brain injury without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.2X1A	Diffuse traumatic brain injury with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.2X2A	Diffuse traumatic brain injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.2X3A	Diffuse traumatic brain injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.2X4A	Diffuse traumatic brain injury with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.2X5A	Diffuse traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious levels, initial encounter	ICD-10-CM	Diagnosis
S06.2X6A	Diffuse traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.2X7A	Diffuse traumatic brain injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.2X8A	Diffuse traumatic brain injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.2X9A	Diffuse traumatic brain injury with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.300A	Unspecified focal traumatic brain injury without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.301A	Unspecified focal traumatic brain injury with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.302A	Unspecified focal traumatic brain injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis

Code	Description	Code Type	Code Category
S06.303A	Unspecified focal traumatic brain injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.304A	Unspecified focal traumatic brain injury with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.305A	Unspecified focal traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.306A	Unspecified focal traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.307A	Unspecified focal traumatic brain injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.308A	Unspecified focal traumatic brain injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.309A	Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.310A	Contusion and laceration of right cerebrum without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.311A	Contusion and laceration of right cerebrum with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.312A	Contusion and laceration of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.313A	Contusion and laceration of right cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.314A	Contusion and laceration of right cerebrum with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.315A	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.316A	Contusion and laceration of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.317A	Contusion and laceration of right cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.318A	Contusion and laceration of right cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.319A	Contusion and laceration of right cerebrum with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.320A	Contusion and laceration of left cerebrum without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S06.321A	Contusion and laceration of left cerebrum with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.322A	Contusion and laceration of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.323A	Contusion and laceration of left cerebrum with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.324A	Contusion and laceration of left cerebrum with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.325A	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.326A	Contusion and laceration of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.327A	Contusion and laceration of left cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.328A	Contusion and laceration of left cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.329A	Contusion and laceration of left cerebrum with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.330A	Contusion and laceration of cerebrum, unspecified, without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.331A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.332A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.333A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.334A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.335A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.336A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.337A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S06.338A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.339A	Contusion and laceration of cerebrum, unspecified, with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.340A	Traumatic hemorrhage of right cerebrum without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.341A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.342A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.343A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.344A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.345A	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.346A	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.347A	Traumatic hemorrhage of right cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.348A	Traumatic hemorrhage of right cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.349A	Traumatic hemorrhage of right cerebrum with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.350A	Traumatic hemorrhage of left cerebrum without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.351A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.352A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.353A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.354A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.355A	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.356A	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S06.357A	Traumatic hemorrhage of left cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.358A	Traumatic hemorrhage of left cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.359A	Traumatic hemorrhage of left cerebrum with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.360A	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.361A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.362A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.363A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.364A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.365A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.366A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.367A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.368A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.369A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.370A	Contusion, laceration, and hemorrhage of cerebellum without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.371A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.372A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.373A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.374A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S06.375A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.376A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.377A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.378A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.379A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.380A	Contusion, laceration, and hemorrhage of brainstem without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.381A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.382A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.383A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.384A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.385A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.386A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.387A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.388A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.389A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.4X0A	Epidural hemorrhage without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.4X1A	Epidural hemorrhage with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.4X2A	Epidural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S06.4X3A	Epidural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.4X4A	Epidural hemorrhage with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.4X5A	Epidural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.4X6A	Epidural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.4X7A	Epidural hemorrhage with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.4X8A	Epidural hemorrhage with loss of consciousness of any duration with death due to other causes prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.4X9A	Epidural hemorrhage with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.5X0A	Traumatic subdural hemorrhage without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.5X1A	Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.5X2A	Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.5X3A	Traumatic subdural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.5X4A	Traumatic subdural hemorrhage with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.5X5A	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.5X6A	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.5X7A	Traumatic subdural hemorrhage with loss of consciousness of any duration with death due to brain injury before regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.5X8A	Traumatic subdural hemorrhage with loss of consciousness of any duration with death due to other cause before regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.5X9A	Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.6X0A	Traumatic subarachnoid hemorrhage without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.6X1A	Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.6X2A	Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.6X3A	Traumatic subarachnoid hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S06.6X4A	Traumatic subarachnoid hemorrhage with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.6X5A	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.6X6A	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.6X7A	Traumatic subarachnoid hemorrhage with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.6X8A	Traumatic subarachnoid hemorrhage with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.6X9A	Traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.810A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.811A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.812A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.813A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.814A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.815A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.816A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.817A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.818A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.819A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.820A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.821A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S06.822A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.823A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.824A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.825A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.826A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.827A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.828A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.829A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.890A	Other specified intracranial injury without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.891A	Other specified intracranial injury with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.892A	Other specified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.893A	Other specified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.894A	Other specified intracranial injury with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.895A	Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.896A	Other specified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.897A	Other specified intracranial injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.898A	Other specified intracranial injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.899A	Other specified intracranial injury with loss of consciousness of unspecified duration, initial encounter	ICD-10-CM	Diagnosis
S06.9X0A	Unspecified intracranial injury without loss of consciousness, initial encounter	ICD-10-CM	Diagnosis

Appendix D. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Baseline Characteristics in this Request

Code	Description	Code Type	Code Category
S06.9X1A	Unspecified intracranial injury with loss of consciousness of 30 minutes or less, initial encounter	ICD-10-CM	Diagnosis
S06.9X2A	Unspecified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.9X3A	Unspecified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	ICD-10-CM	Diagnosis
S06.9X4A	Unspecified intracranial injury with loss of consciousness of 6 hours to 24 hours, initial encounter	ICD-10-CM	Diagnosis
S06.9X5A	Unspecified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	ICD-10-CM	Diagnosis
S06.9X6A	Unspecified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	ICD-10-CM	Diagnosis
S06.9X7A	Unspecified intracranial injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.9X8A	Unspecified intracranial injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	ICD-10-CM	Diagnosis
S06.9X9A	Unspecified intracranial injury with loss of consciousness of unspecified duration, initial	ICD-10-CM	Diagnosis
	Stroke Exclusion Code List 2		
V57	Care involving use of rehabilitation procedures	ICD-9-CM	Diagnosis
V57.0	Care involving breathing exercises	ICD-9-CM	Diagnosis
V57.1	Other physical therapy	ICD-9-CM	Diagnosis
V57.2	Occupational therapy and vocational rehabilitation	ICD-9-CM	Diagnosis
V57.21	Encounter for occupational therapy	ICD-9-CM	Diagnosis
V57.22	Encounter for vocational therapy	ICD-9-CM	Diagnosis
V57.3	Care involving use of rehabilitation speech-language therapy	ICD-9-CM	Diagnosis
V57.4	Orthoptic training	ICD-9-CM	Diagnosis
V57.8	Other specified rehabilitation procedure	ICD-9-CM	Diagnosis
V57.81	Orthotic training	ICD-9-CM	Diagnosis
V57.89	Other specified rehabilitation procedure	ICD-9-CM	Diagnosis
V57.9	Unspecified rehabilitation procedure	ICD-9-CM	Diagnosis
Z51.89	Encounter for other specified aftercare	ICD-10-CM	Diagnosis

Appendix E. Generic and Brand Names of Medical Products Used to Define Baseline Characteristics in this Request

Generic Name	Brand Name
Metformin	
Alogliptin benzoate/metformin HCl	Kazano
Alogliptin benzoate/metformin HCl	Alogliptin-Metformin
Canagliflozin/metformin HCl	Invokamet
Canagliflozin/metformin HCl	Invokamet XR
Dapagliflozin propanediol/metformin HCl	Xigduo XR
Empagliflozin/metformin HCl	Synjardy
Empagliflozin/metformin HCl	Synjardy XR
Ertugliflozin pidolate/metformin HCl	Segluromet
Glipizide/metformin HCl	Glipizide-Metformin
Glyburide/metformin HCl	Glyburide-Metformin
Glyburide/metformin HCl	Glucovance
Linagliptin/metformin HCl	Jentadueto
Linagliptin/metformin HCl	Jentadueto XR
Metformin HCl	Metformin
Metformin HCl	Glucophage XR
Metformin HCl	Glumetza
Metformin HCl	Glucophage
Metformin HCl	Riomet
Metformin HCl	Fortamet
Pioglitazone HCl/metformin HCl	Pioglitazone-Metformin
Pioglitazone HCl/metformin HCl	Actoplus MET
Pioglitazone HCl/metformin HCl	Actoplus Met XR
Repaglinide/metformin HCl	Prandimet
Repaglinide/metformin HCl	Repaglinide-Metformin
Rosiglitazone maleate/metformin HCl	Avandamet
Saxagliptin HCl/metformin HCl	Kombiglyze XR
Sitagliptin phosphate/metformin HCl	Janumet
Sitagliptin phosphate/metformin HCl	Janumet XR
Sulfonylureas	
Glimepiride	Glimepiride
Glimepiride	Amaryl
Glipizide	Glipizide
Glipizide	Glucotrol Xl
Glipizide	Glucotrol
Glipizide/metformin HCl	Glipizide-Metformin
Glyburide	Glyburide
Glyburide	Diabeta
Glyburide,micronized	Glyburide Micronized
Glyburide,micronized	Glynase
Glyburide/metformin HCl	Glyburide-Metformin
Glyburide/metformin HCl	Glucovance

Appendix E. Generic and Brand Names of Medical Products Used to Define Baseline Characteristics in this Request

Generic Name	Brand Name
Pioglitazone HCl/glimepiride	Pioglitazone-Glimepiride
Pioglitazone HCl/glimepiride	Duetact
Rosiglitazone maleate/glimepiride	Avandaryl
Sodium-Glucose Co-Transporter-2 (SGLT-2) Inhibitors	
Canagliflozin	Invokana
Canagliflozin/metformin HCl	Invokamet
Canagliflozin/metformin HCl	Invokamet XR
Dapagliflozin propanediol	Farxiga
Dapagliflozin propanediol/metformin HCl	Xigduo XR
Dapagliflozin propanediol/saxagliptin HCl	Qtern
Empagliflozin	Jardiance
Empagliflozin/linagliptin	Glyxambi
Empagliflozin/metformin HCl	Synjardy
Empagliflozin/metformin HCl	Synjardy XR
Ertugliflozin pidolate	Steglatro
Ertugliflozin pidolate/metformin HCl	Segluromet
Ertugliflozin pidolate/sitagliptin phosphate	Steglujan
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	
Alogliptin benzoate	Nesina
Alogliptin benzoate	Alogliptin
Alogliptin benzoate/metformin HCl	Alogliptin-Metformin
Alogliptin benzoate/metformin HCl	Kazano
Dapagliflozin propanediol/saxagliptin HCl	Qtern
Empagliflozin/linagliptin	Glyxambi
Ertugliflozin pidolate/sitagliptin phosphate	Steglujan
Linagliptin	Tradjenta
Linagliptin/metformin HCl	Jentadueto XR
Linagliptin/metformin HCl	Jentadueto
Saxagliptin HCl	Onglyza
Saxagliptin HCl/metformin HCl	Kombiglyze XR
Sitagliptin phosphate	Januvia
Sitagliptin phosphate/metformin HCl	Janumet
Sitagliptin phosphate/metformin HCl	Janumet XR
Sitagliptin phosphate/simvastatin	Juvisync
Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists	
Albiglutide	Tanzeum
Dulaglutide	Trulicity
Exenatide	Byetta
Exenatide microspheres	Bydureon BCise
Exenatide microspheres	Bydureon
Insulin degludec/liraglutide	Xultophy 100/3.6
Insulin glargine,human recombinant analog/lixisenatide	Soliqua 100/33

Appendix E. Generic and Brand Names of Medical Products Used to Define Baseline Characteristics in this Request

Generic Name	Brand Name
Liraglutide	Victoza 2-Pak
Lixisenatide	Adlyxin
Semaglutide	Rybelsus
Semaglutide	Ozempic
Thiazolidinediones	
Alogliptin benzoate/pioglitazone HCl	Alogliptin-Pioglitazone
Alogliptin benzoate/pioglitazone HCl	Oseni
Pioglitazone HCl	Pioglitazone
Pioglitazone HCl	Actos
Pioglitazone HCl/glimepiride	Pioglitazone-Glimepiride
Pioglitazone HCl/glimepiride	Duetact
Pioglitazone HCl/metformin HCl	Pioglitazone-Metformin
Pioglitazone HCl/metformin HCl	Actoplus MET
Pioglitazone HCl/metformin HCl	Actoplus Met XR
Rosiglitazone maleate	Avandia
Rosiglitazone maleate/glimepiride	Avandaryl
Rosiglitazone maleate/metformin HCl	Avandamet

Appendix F. Specifications Defining Baseline Characteristic Parameters in this Request

Baseline Characteristics						
Characteristic	**Combo Covariate Component**	**Care Setting/Principal Diagnosis Position[1]**	**Evaluation Period Start (days)**	**Evaluation Period End (days)**	**Exclude Days Supply**	**Code Days[2]**
Diabetes Characteristics						
Type 1 diabetes	Type 1 diabetes mellitus (T1DM) codes	Any	-183	0	N/A	1
	No type 2 diabetes mellitus (T2DM) codes	Any	-183	0	N/A	1
Type 2 diabetes	T2DM codes	Any	-183	0	N/A	1
	No T1DM codes	Any	-183	0	N/A	1
Type 1 or type 2 diabetes	T1DM codes	Any	-183	0	N/A	1
	T2DM codes	Any	-183	0	N/A	1
No Type 1 or type 2 diabetes	No T1DM codes	Any	-183	0	N/A	1
	No T2DM codes	Any	-183	0	N/A	1
Anti-Diabetic Agents						
Metformin		Any	-183	0	Look for evidence of days supply	1
Sodium-glucose co-transporter-2 (SGLT-2) inhibitors		Any	-183	0	Look for evidence of days supply	1
Dipeptidyl peptidase-4 (DPP-4) inhibitors		Any	-183	0	Look for evidence of days supply	1
Glucagon-like peptide-1 (GLP-1) receptor agonists		Any	-183	0	Look for evidence of days supply	1
Sulfonylureas		Any	-183	0	Look for evidence of days supply	1
Thiazolidinediones		Any	-183	0	Look for evidence of days supply	1
Chronic Conditions Warehouse Characteristics[3]						
Acquired hypothyroidism		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Acute myocardial infarction		IPP, IPS	-183	0	N/A	1
Alzheimer's disease and related dementias		Any	-183	0	N/A	1
Anemia		Any	-183	0	N/A	1

Appendix F. Specifications Defining Baseline Characteristic Parameters in this Request

Baseline Characteristics						
Characteristic	**Combo Covariate Component**	**Care Setting/Principal Diagnosis Position[1]**	**Evaluation Period Start (days)**	**Evaluation Period End (days)**	**Exclude Days Supply**	**Code Days[2]**
Asthma		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Atrial fibrillation		IPP, IPS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Benign prostatic hyperplasia (BPH)		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
	AND **NOT** BPH exclusion codes	Any	-183	0	N/A	1
Breast cancer		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Cataract		AV, ED, OA	-183	0	N/A	1
Chronic kidney disease		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Chronic obstructive pulmonary disease (COPD) and bronchiectasis		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Colorectal cancer		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2

Appendix F. Specifications Defining Baseline Characteristic Parameters in this Request

Baseline Characteristics						
Characteristic	**Combo Covariate Component**	**Care Setting/Principal Diagnosis Position[1]**	**Evaluation Period Start (days)**	**Evaluation Period End (days)**	**Exclude Days Supply**	**Code Days[2]**
Depression		Any	-183	0	N/A	1
Diabetes		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Endometrial cancer		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Glaucoma		AV, ED, OA	-183	0	N/A	1
Heart failure		IP, AV, ED, OA	-183	0	N/A	1
Hip/pelvic fracture		IP, IS	-183	0	N/A	1
Hyperlipidemia		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Hypertension		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Ischemic heart disease		Any	-183	0	N/A	1
Lung cancer		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Osteoporosis		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2

Appendix F. Specifications Defining Baseline Characteristic Parameters in this Request

Baseline Characteristics						
Characteristic	**Combo Covariate Component**	**Care Setting/Principal Diagnosis Position[1]**	**Evaluation Period Start (days)**	**Evaluation Period End (days)**	**Exclude Days Supply**	**Code Days[2]**
Prostate cancer		IP, IS	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
Rheumatoid arthritis/osteoarthritis		Any	-183	0	N/A	2
Stroke/transient ischemic attack		IP	-183	0	N/A	1
				OR		
		AV, ED, OA	-183	0	N/A	2
	AND **NOT** Stroke exclusion code list 1	Any	-183	0	N/A	1
	AND **NOT** Stroke exclusion code list 2	IPP	-183	0	N/A	1

[1]Care Setting/Principal Diagnosis Position Options:

Ambulatory Visit (AV) - includes visits at outpatient clinics, same-day surgeries, urgent care visits, and other same-day ambulatory hospital encounters, but excludes emergency department encounters.

Emergency Department (ED) - includes ED encounters that become inpatient stays (in which case inpatient stays would be a separate encounter). Excludes urgent care visits.

Inpatient Hospital Stay (IP) - includes all inpatient stays, same-day hospital discharges, hospital transfers, and acute hospital care where the discharge is after the admission date.

Non-Acute Institutional Stay (IS) - includes hospice, skilled nursing facility (SNF), rehab center, nursing home, residential, overnight non-hospital dialysis and other non-hospital stays.

Other Ambulatory Visit (OA) - includes other non overnight AV encounters such as hospice visits, home health visits, skilled nursing facility visits, other non-hospital visits, as well as telemedicine, telephone and email consultations.

Principal Diagnosis Position - 'IPP' = inpatient principal diagnosis position, 'IPS' = inpatient secondary diagnosis position.

[2]Code days represents the minimum number of times the characteristic should be found in the baseline period.

[3]Centers for Medicare and Medicaid Services. (2018). "Chronic Conditions Data Warehouse." Available at: https://www.ccwdata.org/web/guest/condition-categories.

Please note in this request some criteria for occurrence of claims to identify the conditions and reference periods have been modified from those specified in the CCW algorithm. For conditions requiring two separate code occurrences, two codes must occur within 365 days of the drug index date, not within 365 days of one another.

Appendix G. Specifications Defining Parameters in this Request

This request used the Cohort Identification and Descriptive Analysis (CIDA) module, version 9.3.0 to investigate the billing code patterns of insulin in the Sentinel Distributed Database (SDD).

Query Period: January 1, 2013 to December 31, 2018
Coverage Requirement: Medical & Drug Coverage
Pre-index Enrollment Requirement: 183 days
Post-index Enrollment Requirement: 0 days
Enrollment Gap: 45 days
Age Groups: 18-44, 45-64, 65+ years
Stratifications: N/A
Restrictions: Male and Female only
Envelope Macro: Reclassify encounters during inpatient stay as inpatient

	Exposure											
Scenario	Index Exposure	Cohort Definition	Incident Exposure Washout Period	Incident with Respect to:	Exclude Evidence of Days Supply if Exposure Washout includes Dispensings	Treatment Episode Gap	Episode Extension Period	Care Setting	Principal Diagnosis Position	Forced Supply to Attach to Dispensings	Forced Supply to Attach to Procedure Codes	Censor Treatment Episode at Evidence of:
1	Insulin (defined using National Drug Codes (NDCs))	Include all valid exposure episodes during query period; (only the first valid exposure episode's incidence is assessed using washout criteria)	0 days (only the first valid episode's incidence is assessed using washout criteria)	N/A	N/A	30 days	30 days	N/A	N/A	N/A	N/A	Episode end (greater than 30 day gap); Healthcare Common Procedure Coding System (HCPCS) insulin code; Death; Data Partner (DP) end date; Query end date

Appendix G. Specifications Defining Parameters in this Request

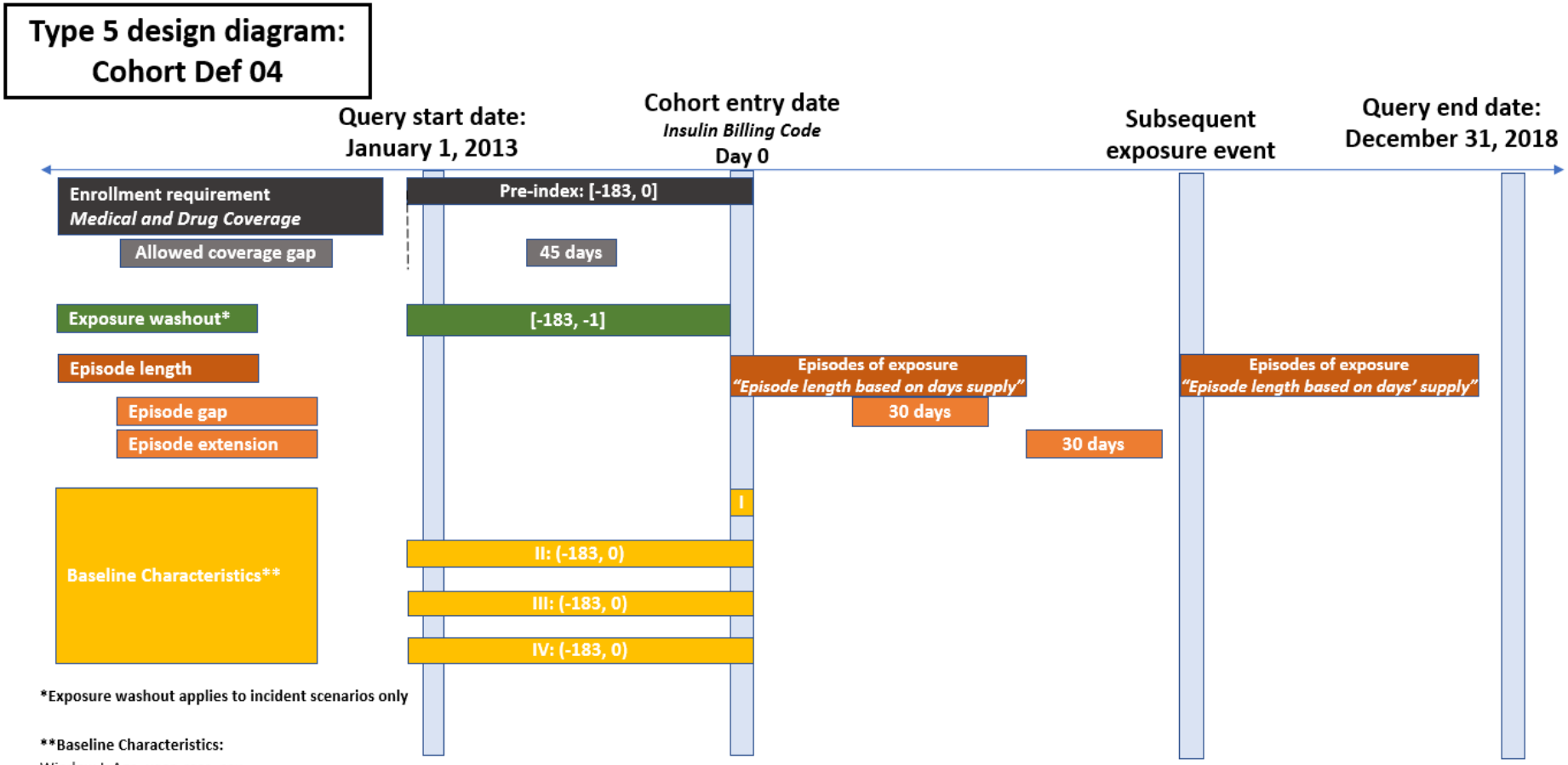
	Exposure											
Scenario	Index Exposure	Cohort Definition	Incident Exposure Washout Period	Incident with Respect to:	Exclude Evidence of Days Supply if Exposure Washout includes Dispensings	Treatment Episode Gap	Episode Extension Period	Care Setting	Principal Diagnosis Position	Forced Supply to Attach to Dispensings	Forced Supply to Attach to Procedure Codes	Censor Treatment Episode at Evidence of:
2	Insulin (defined using HCPCS)	Include all valid exposure episodes during query period; (only the first valid exposure episode's incidence is assessed using washout criteria)	0 days (only the first valid episode's incidence is assessed using washout criteria)	N/A	N/A	30 days	30 days	N/A	N/A	N/A	N/A (1 day supply)	Episode end (greater than 30 day gap); NDC insulin code; Death; DP end date; Query end date
3	Insulin (defined using NDCs or HCPCS)	Include all valid exposure episodes during query period; (only the first valid exposure episode's incidence is assessed using washout criteria)	0 days (only the first valid episode's incidence is assessed using washout criteria)	N/A	N/A	30 days	30 days	N/A	N/A	N/A	N/A	Episode end (greater than 30 day gap); Death; DP end date; Query end date
4	Insulin (defined using NDCs)	Include all valid exposure episodes during query period; (only the first valid exposure episode's incidence is assessed using washout criteria)	183 days (only the first valid episode's incidence is assessed using washout criteria)	Insulin (defined using NDCs)	Washout lookback period should search for evidence of days supply	30 days	30 days	N/A	N/A	N/A	N/A	Episode end (greater than 30 day gap); HCPCS insulin code; Death; DP end date; Query end date

Appendix G. Specifications Defining Parameters in this Request

	Exposure											
Scenario	**Index Exposure**	**Cohort Definition**	**Incident Exposure Washout Period**	**Incident with Respect to:**	**Exclude Evidence of Days Supply if Exposure Washout includes Dispensings**	**Treatment Episode Gap**	**Episode Extension Period**	**Care Setting**	**Principal Diagnosis Position**	**Forced Supply to Attach to Dispensings**	**Forced Supply to Attach to Procedure Codes**	**Censor Treatment Episode at Evidence of:**
5	Insulin (defined using HCPCS)	Include all valid exposure episodes during query period; (only the first valid exposure episode's incidence is assessed using washout criteria)	183 days (only the first valid episode's incidence is assessed using washout criteria)	Insulin (defined using HCPCS)	Washout lookback period should search for evidence of days supply	30 days	30 days	N/A	N/A	N/A	N/A (1 day supply)	Episode end (greater than 30 day gap); NDC insulin code; Death; DP end date; Query end date
6	Insulin (defined using NDCs or HCPCS)	Include all valid exposure episodes during query period; (only the first valid exposure episode's incidence is assessed using washout criteria)	183 days (only the first valid episode's incidence is assessed using washout criteria)	Insulin (defined using NDCs and HCPCS)	Washout lookback period should search for evidence of days supply	30 days	30 days	N/A	N/A	N/A	N/A	Episode end (greater than 30 day gap); Death; DP end date; Query end date

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9), International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10), Healthcare Common Procedure Coding System (HCPCS), and Current Procedural Terminology, Fourth Edition (CPT-4) codes are provided by Optum360.

National Drug Codes (NDCs) codes are checked against First Data Bank's "FDB MedKnowledge®" database.



*Exposure washout applies to incident scenarios only

**Baseline Characteristics:

Window I: Age, year, race, sex

Window II: Diabetes category (Type 1 Diabetes, Type 2 Diabetes, Type 1 or Type 2 Diabetes, Neither Type 1 nor Type 2 Diabetes)

Window III: Chronic Conditions Warehouse characteristics (Acquired hypothyroidism, Acute myocardial infarction, Alzheimer's disease and related conditions, Anemia, Asthma, Atrial fibrillation, Benign prostatic hyperplasia, Breast cancer, Cataracts, Chronic kidney disease, Chronic obstructive pulmonary disorder and bronchiectasis, Colorectal cancer, Depression, Endometrial cancer, Glaucoma, Heart failure, Hip/pelvic fracture, Hyperlipidemia, Hypertension, Ischemic heart disease, Lung cancer, Osteoporosis, Prostate cancer, Rheumatoid arthritis/osteoarthritis, Stroke/transient ischemic attack)

Window IV: Anti-diabetic agents (metformin, SGLT-2 inhibitors, DPP-4 inhibitors, GLP-1 receptor agonists, sulfonylureas, thiazolidinediones