Sentinel

Disclaimer

The following report(s) provides findings from an FDA-initiated query using Sentinel. While Sentinel queries may be undertaken to assess potential medical product 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).

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Sentinel

Overview for Request: cder_mpl1p_wp109, Report 3 of 3

Request ID: cder_mpl1p_wp109 (r03)

Request Description: In this report, we describe the information captured in the prescribing and dispensing tables in the Sentinel Common Data Model (SCDM) by examining how dispensings relate to prescriptions, and vice versa, for the following drugs in the Sentinel Distributed Database (SDD): amoxapine, isoniazid, atogepant, inclisiran, and finerenone. This is report 3 of 3, in which members index on a qualifying drug dispensing, and pre-index prescriptions of the index drug are assessed. In reports 1 and 2, members index on a qualifying prescription, using two different post-index continuous enrollment requirements, and post-index dispensings or administrations of the index prescription are assessed.

Sentinel Routine Querying Module: Cohort Identification and Descriptive Analysis (CIDA) module, version 14.2.1

Data Source: We distributed this query to three Sentinel Data Partners on November 7, 2025. The three Data Partners comprise a subset of the SDD with availability of both prescribing and dispensing data and do not include Centers of Medicare and Medicaid Services (CMS) Medicare or Medicaid data. The study period included data from January 1, 2016 through May 31, 2025. Please see Appendix A for a list of dates of available data for each Data Partner.

Study Design: We identified dispensings of each drug of interest, with the date of the first eligible dispensing serving as the index date, and evaluated the evidence of prescriptions of that drug within 365 days before the index date (inclusive). This is a Type 2 analysis in the Query Request Package (QRP) documentation.

Exposures of Interest: The cohort-defining drugs of interest were amoxapine, isoniazid, atogepant, inclisiran, and finerenone; dispensings of these drugs were identified using National Drug Codes (NDCs) in the SCDM Dispensing Table . Please refer to Appendix B for generic and brand names of medical products used to define exposures in this request.

Outcomes of Interest: There was no outcome of interest.

Cohort Eligibility Criteria: We required members to be enrolled in health plans with medical and drug coverage in the 365 days prior to their index dispensing date; a gap in coverage of up to 45 days was allowed and treated as continuous enrollment. Eligible patients were incident users.

The following age groups were included in the cohort: 0-17, 18-24, 25-40, 41-64, 65+ years.

Follow-up Time: There was no post-index follow-up period.

Baseline Characteristics: Age, sex, race, ethnicity, and calendar year were assessed on the index date. The following health characteristics were assessed in the in 365 days leading up to the index date (days -365 through 0): combined comorbidity score, acute myocardial infarction, Alzheimer's disease, anemia, asthma, atrial fibrillation/flutter, chronic kidney disease, chronic obstructive pulmonary disease, depressive mood disorders, diabetes, heart failure/non-ischemic heart disease, hyperlipidemia, hypertension, ischemic heart disease, non-Alzheimer's dementia, Parkinson's disease/secondary parkinsonism, all-cause pneumonia, and stroke/transient ischemic attack. Prior medical product use and drug utilization were assessed within 365 days prior to the index date (days -365 through -1). Please see Appendix C for a list of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes used to define baseline characteristics in this request.

Addtionally, for each cohort, we assessed the evidence of prescriptions of the cohort-defining drug on or before the index dispensing within the following categories: 0-30 days, 31-60 days, 61-90 days, 91-183 days, and 184-365 days. Prescriptions for the cohort-defining drugs were identified using National Drug Codes (NDCs) or Generic Product Identifiers (GPIs), as appropriate for each Data Partner. Please refer to Appendix D for generic and brand names of medical products used to define prescriptions as characteristics in this request.

Overview for Request: cder_mpl1p_wp109, Report 3 of 3
Limitations: Algorithms used to define exposures and inclusion/exclusion criteria are imperfect; thus, it is possible that there may be misclassification. Therefore, data should be interpreted with these limitations 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).

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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.

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

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. Aggregated Characteristics of Patients Dispensed Amoxapine in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Amoxapine	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Unique patients	14	N/A
Demographic Characteristics		
Age (years)	65.3	17.4
Age		
0-17 years	0	0.0%
18-24 years	*****	*****
25-40 years	0	0.0%
41-64 years	*****	*****
≥ 65 years	*****	*****
Sex		
Female	*****	*****
Male	*****	*****
Race[2]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	0	0.0%
Multi-racial	*****	*****
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	*****	*****
White	11	78.6%
Hispanic origin		
Yes	0	0.0%
No	*****	*****
Unknown	*****	*****
Year		
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	*****	*****
2020	0	0.0%
2021	0	0.0%
2022	*****	*****
2023	*****	*****
2024	0	0.0%
2025	0	0.0%

Table 1a. Aggregated Characteristics of Patients Dispensed Amoxapine in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Amoxapine	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Health Characteristics		
Combined comorbidity score[3]	3.1	3.4
Combined comorbidity score categories		
<=0	*****	*****
1-2	*****	*****
3-4	*****	*****
>=5	*****	*****
Evidence of amoxapine prescription before dispensing		
Amoxapine prescription 0-30 days before dispensing	*****	*****
Amoxapine prescription 31-60 days before dispensing	0	0.0%
Amoxapine prescription 61-90 days before dispensing	0	0.0%
Amoxapine prescription 91-183 days before dispensing	0	0.0%
Amoxapine prescription 184-365 days before dispensing	0	0.0%
Acute myocardial infarction	0	0.0%
Alzheimer's disease	0	0.0%
Anemia	*****	*****
Asthma	*****	*****
Atrial fibrillation or flutter	*****	*****
Chronic kidney disease	*****	*****
Chronic obstructive pulmonary disease	*****	*****
Bipolar or other depressive mood disorders	*****	*****
Diabetes	*****	*****
Heart failure or non-ischemic heart disease	*****	*****
Hyperlipidemia	*****	*****
Hypertension	*****	*****
Ischemic heart disease	*****	*****
Non-Alzheimer's dementia	0	0.0%
Parkinson'sdisease or secondary parkinsonism	*****	*****
Pneumonia (all cause)	*****	*****
Stroke or transient ischemic attack	0	0.0%
Health Service Utilization Intensity Metrics		
Mean number of ambulatory encounters	32.4	17.2
Mean number of emergency room encounters	0.4	1.0
Mean number of inpatient hospital encounters	0.5	1.0
Mean number of non-acute institutional encounters	1.3	4.9

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Table 1a. Aggregated Characteristics of Patients Dispensed Amoxapine in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Amoxapine	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Mean number of other ambulatory encounters	20.6	18.5
Mean number of filled prescriptions	66.9	48.6
Mean number of generics dispensed	14.1	6.9
Mean number of unique drug classes dispensed	12.9	6.4

[1]Value represents standard deviation where no % follows the value.

[2]Race data may not be completely populated at all Data Partners; therefore, data about race may be incomplete.

[3]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. Sun JW, Rogers JR, Her Q, Welch EC, Panozzo CA, Toh S, Gagne JJ. Adaptation and validation of the combined comorbidity score for ICD-10-CM. Med Care. 2017;55(12):1046-1051.

*****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.

N/A: Not applicable

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Table 1b. Aggregated Characteristics of Patients Dispensed Isoniazid in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Isoniazid	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Unique patients	1,389	N/A
Demographic Characteristics		
Age (years)	45.3	17.5
Age		
0-17 years	66	4.8%
18-24 years	105	7.6%
25-40 years	418	30.1%
41-64 years	607	43.7%
≥ 65 years	193	13.9%
Sex		
Female	797	57.4%
Male	592	42.6%
Race[2]		
American Indian or Alaska Native	*****	*****
Asian	301	21.7%
Black or African American	379	27.3%
Multi-racial	112	8.1%
Native Hawaiian or Other Pacific Islander	*****	*****
Unknown	261	18.8%
White	319	23.0%
Hispanic origin		
Yes	124	8.9%
No	987	71.1%
Unknown	278	20.0%
Year		
2016	232	16.7%
2017	194	14.0%
2018	192	13.8%
2019	168	12.1%
2020	100	7.2%
2021	116	8.4%
2022	129	9.3%
2023	136	9.8%
2024	82	5.9%
2025	40	2.9%

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Table 1b. Aggregated Characteristics of Patients Dispensed Isoniazid in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Isoniazid	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Health Characteristics		
Combined comorbidity score[3]	1.1	2.3
Combined comorbidity score categories		
<=0	779	56.1%
1-2	406	29.2%
3-4	101	7.3%
>=5	103	7.4%
Evidence of isoniazid prescription before dispensing		
Isoniazid prescription 0-30 days before dispensing	715	51.5%
Isoniazid prescription 31-60 days before dispensing	29	2.1%
Isoniazid prescription 61-90 days before dispensing	23	1.7%
Isoniazid prescription 91-183 days before dispensing	61	4.4%
Isoniazid prescription 184-365 days before dispensing	43	3.1%
Acute myocardial infarction	13	0.9%
Alzheimer's disease	*****	*****
Anemia	221	15.9%
Asthma	114	8.2%
Atrial fibrillation or flutter	42	3.0%
Chronic kidney disease	136	9.8%
Chronic obstructive pulmonary disease	92	6.6%
Bipolar or other depressive mood disorders	216	15.6%
Diabetes	232	16.7%
Heart failure or non-ischemic heart disease	53	3.8%
Hyperlipidemia	335	24.1%
Hypertension	385	27.7%
Ischemic heart disease	70	5.0%
Non-Alzheimer's dementia	*****	*****
Parkinson'sdisease or secondary parkinsonism	*****	*****
Pneumonia (all cause)	90	6.5%
Stroke or transient ischemic attack	14	1.0%
Health Service Utilization Intensity Metrics		
Mean number of ambulatory encounters	16.8	26.2
Mean number of emergency room encounters	0.4	1.2
Mean number of inpatient hospital encounters	0.2	0.7
Mean number of non-acute institutional encounters	0.1	1.0

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Table 1b. Aggregated Characteristics of Patients Dispensed Isoniazid in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Isoniazid	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Mean number of other ambulatory encounters	11.1	15.2
Mean number of filled prescriptions	17.8	22.9
Mean number of generics dispensed	6.4	6.1
Mean number of unique drug classes dispensed	5.9	5.4

[1]Value represents standard deviation where no % follows the value.

[2]Race data may not be completely populated at all Data Partners; therefore, data about race may be incomplete.

[3]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. Sun JW, Rogers JR, Her Q, Welch EC, Panozzo CA, Toh S, Gagne JJ. Adaptation and validation of the combined comorbidity score for ICD-10-CM. Med Care. 2017;55(12):1046-1051.

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N/A: Not applicable

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Table 1c. Aggregated Characteristics of Patients Dispensed Atogepant in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Atogepant	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Unique patients	303	N/A
Demographic Characteristics		
Age (years)	47.6	12.9
Age		
0-17 years	*****	*****
18-24 years	*****	*****
25-40 years	82	27.1%
41-64 years	188	62.0%
≥ 65 years	20	6.6%
Sex		
Female	264	87.1%
Male	39	12.9%
Race[2]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	11	3.6%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	58	19.1%
White	225	74.3%
Hispanic origin		
Yes	*****	*****
No	212	70.0%
Unknown	*****	*****
Year		
2016	0	0.0%
2017	0	0.0%
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	0	0.0%
2022	44	14.5%
2023	86	28.4%
2024	113	37.3%
2025	60	19.8%

Table 1c. Aggregated Characteristics of Patients Dispensed Atogepant in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Atogepant	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Health Characteristics		
Combined comorbidity score[3]	1.1	1.5
Combined comorbidity score categories		
<=0	134	44.2%
1-2	124	40.9%
3-4	32	10.6%
>=5	13	4.3%
Evidence of atogepant prescription before dispensing		
Atogepant prescription 0-30 days before dispensing	62	20.5%
Atogepant prescription 31-60 days before dispensing	*****	*****
Atogepant prescription 61-90 days before dispensing	*****	*****
Atogepant prescription 91-183 days before dispensing	*****	*****
Atogepant prescription 184-365 days before dispensing	*****	*****
Acute myocardial infarction	*****	*****
Alzheimer's disease	*****	*****
Anemia	20	6.6%
Asthma	47	15.5%
Atrial fibrillation or flutter	*****	*****
Chronic kidney disease	22	7.3%
Chronic obstructive pulmonary disease	12	4.0%
Bipolar or other depressive mood disorders	138	45.5%
Diabetes	22	7.3%
Heart failure or non-ischemic heart disease	*****	*****
Hyperlipidemia	92	30.4%
Hypertension	80	26.4%
Ischemic heart disease	*****	*****
Non-Alzheimer's dementia	*****	*****
Parkinson'sdisease or secondary parkinsonism	*****	*****
Pneumonia (all cause)	*****	*****
Stroke or transient ischemic attack	*****	*****
Health Service Utilization Intensity Metrics		
Mean number of ambulatory encounters	25.9	20.6
Mean number of emergency room encounters	0.7	1.7
Mean number of inpatient hospital encounters	0.1	0.3
Mean number of non-acute institutional encounters	0.0	0.2

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Table 1c. Aggregated Characteristics of Patients Dispensed Atogepant in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Atogepant	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Mean number of other ambulatory encounters	13.6	19.4
Mean number of filled prescriptions	48.6	41.6
Mean number of generics dispensed	13.5	7.6
Mean number of unique drug classes dispensed	11.9	6.8

[1]Value represents standard deviation where no % follows the value.

[2]Race data may not be completely populated at all Data Partners; therefore, data about race may be incomplete.

[3]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. Sun JW, Rogers JR, Her Q, Welch EC, Panozzo CA, Toh S, Gagne JJ. Adaptation and validation of the combined comorbidity score for ICD-10-CM. Med Care. 2017;55(12):1046-1051.

*****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.

N/A: Not applicable

Table 1d. Aggregated Characteristics of Patients Dispensed Inclisiran in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025[1]

	Inclisiran	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[2]**
Unique patients	*****	*****
Demographic Characteristics		
Age (years)	75.2	NaN
Age		
0-17 years	0	0.0%
18-24 years	0	0.0%
25-40 years	0	0.0%
41-64 years	0	0.0%
≥ 65 years	*****	*****
Sex		
Female	*****	*****
Male	0	0.0%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	0	0.0%
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	0	0.0%
White	*****	*****
Hispanic origin		
Yes	0	0.0%
No	*****	*****
Unknown	0	0.0%
Year		
2016	0	0.0%
2017	0	0.0%
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	0	0.0%
2022	*****	*****
2023	0	0.0%
2024	0	0.0%
2025	0	0.0%

Table 1d. Aggregated Characteristics of Patients Dispensed Inclisiran in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025[1]

	Inclisiran	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[2]**
Health Characteristics		
Combined comorbidity score[4]	2.0	NaN
Combined comorbidity score categories		
<=0	0	0.0%
1-2	*****	*****
3-4	0	0.0%
>=5	0	0.0%
Evidence of inclisiran prescription before dispensing		
Inclisiran prescription 0-30 days before dispensing	0	0.0%
Inclisiran prescription 31-60 days before dispensing	0	0.0%
Inclisiran prescription 61-90 days before dispensing	0	0.0%
Inclisiran prescription 91-183 days before dispensing	0	0.0%
Inclisiran prescription 184-365 days before dispensing	0	0.0%
Acute myocardial infarction	0	0.0%
Alzheimer's disease	0	0.0%
Anemia	0	0.0%
Asthma	*****	*****
Atrial fibrillation or flutter	0	0.0%
Chronic kidney disease	0	0.0%
Chronic obstructive pulmonary disease	*****	*****
Bipolar or other depressive mood disorders	0	0.0%
Diabetes	0	0.0%
Heart failure or non-ischemic heart disease	0	0.0%
Hyperlipidemia	*****	*****
Hypertension	*****	*****
Ischemic heart disease	*****	*****
Non-Alzheimer's dementia	0	0.0%
Parkinson'sdisease or secondary parkinsonism	0	0.0%
Pneumonia (all cause)	0	0.0%
Stroke or transient ischemic attack	0	0.0%
Health Service Utilization Intensity Metrics		
Mean number of ambulatory encounters	18.0	NaN
Mean number of emergency room encounters	2.0	NaN
Mean number of inpatient hospital encounters	0.0	NaN
Mean number of non-acute institutional encounters	0.0	NaN

Sentinel

Table 1d. Aggregated Characteristics of Patients Dispensed Inclisiran in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025[1]

	Inclisiran	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[2]**
Mean number of other ambulatory encounters	26.0	NaN
Mean number of filled prescriptions	52.0	NaN
Mean number of generics dispensed	16.0	NaN
Mean number of unique drug classes dispensed	15.0	NaN

[1]Inclisiran exposures were identified using inclisiran National Drug Codes in the Sentinel Common Data Model (SCDM) Dispensing Table; inclisiran procedure codes in the SCDM Procedure Table were not considered for exposure identification.

[2]Value represents standard deviation where no % follows the value.

[3]Race data may not be completely populated at all Data Partners; therefore, data about race may be incomplete.

[4]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. Sun JW, Rogers JR, Her Q, Welch EC, Panozzo CA, Toh S, Gagne JJ. Adaptation and validation of the combined comorbidity score for ICD-10-CM. Med Care. 2017;55(12):1046-1051.

*****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.

N/A: Not applicable

Data represented by NaN (Not a Number) is due to their inability to be calculated.

Table 1e. Aggregated Characteristics of Patients Dispensed Finerenone in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Finerenone	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Unique patients	113	N/A
Demographic Characteristics		
Age (years)	64.6	13.4
Age		
0-17 years	0	0.0%
18-24 years	*****	*****
25-40 years	*****	*****
41-64 years	46	40.7%
≥ 65 years	58	51.3%
Sex		
Female	42	37.2%
Male	71	62.8%
Race[2]		
American Indian or Alaska Native	0	0.0%
Asian	14	12.4%
Black or African American	*****	*****
Multi-racial	*****	*****
Native Hawaiian or Other Pacific Islander	*****	*****
Unknown	28	24.8%
White	62	54.9%
Hispanic origin		
Yes	*****	*****
No	68	60.2%
Unknown	*****	*****
Year		
2016	0	0.0%
2017	0	0.0%
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	0	0.0%
2022	13	11.5%
2023	32	28.3%
2024	47	41.6%
2025	21	18.6%

Table 1e. Aggregated Characteristics of Patients Dispensed Finerenone in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Finerenone	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Health Characteristics		
Combined comorbidity score[3]	3.5	2.5
Combined comorbidity score categories		
<=0	12	10.6%
1-2	38	33.6%
3-4	30	26.5%
>=5	33	29.2%
Evidence of finerenone prescription before dispensing		
Finerenone prescription 0-30 days before dispensing	37	32.7%
Finerenone prescription 31-60 days before dispensing	*****	*****
Finerenone prescription 61-90 days before dispensing	*****	*****
Finerenone prescription 91-183 days before dispensing	*****	*****
Finerenone prescription 184-365 days before dispensing	*****	*****
Acute myocardial infarction	*****	*****
Alzheimer's disease	*****	*****
Anemia	30	26.5%
Asthma	12	10.6%
Atrial fibrillation or flutter	12	10.6%
Chronic kidney disease	104	92.0%
Chronic obstructive pulmonary disease	*****	*****
Bipolar or other depressive mood disorders	18	15.9%
Diabetes	109	96.5%
Heart failure or non-ischemic heart disease	21	18.6%
Hyperlipidemia	90	79.6%
Hypertension	106	93.8%
Ischemic heart disease	32	28.3%
Non-Alzheimer's dementia	*****	*****
Parkinson'sdisease or secondary parkinsonism	0	0.0%
Pneumonia (all cause)	*****	*****
Stroke or transient ischemic attack	*****	*****
Health Service Utilization Intensity Metrics		
Mean number of ambulatory encounters	20.7	16.8
Mean number of emergency room encounters	0.5	1.2
Mean number of inpatient hospital encounters	0.2	0.9
Mean number of non-acute institutional encounters	0.0	0.2

Table 1e. Aggregated Characteristics of Patients Dispensed Finerenone in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Finerenone	
Patient Characteristics	**Number/Mean**	**Percent/ Standard Deviation[1]**
Mean number of other ambulatory encounters	21.5	20.8
Mean number of filled prescriptions	47.2	22.6
Mean number of generics dispensed	13.1	6.2
Mean number of unique drug classes dispensed	11.0	5.3

[1]Value represents standard deviation where no % follows the value.

[2]Race data may not be completely populated at all Data Partners; therefore, data about race may be incomplete.

[3]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. Sun JW, Rogers JR, Her Q, Welch EC, Panozzo CA, Toh S, Gagne JJ. Adaptation and validation of the combined comorbidity score for ICD-10-CM. Med Care. 2017;55(12):1046-1051.

*****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.

N/A: Not applicable

Table 2. Summary of Patient-Level Cohort Attrition in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Amoxapine Dispensing from the Dispensing Table		Isoniazid Dispensing from the Dispensing Table		Atogepant Dispensing from the Dispensing Table		Inclisiran Dispensing from the Dispensing Table		Finerenone Dispensing from the Dispensing Table	
	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded
Members meeting enrollment and demographic requirements										
Enrolled at any point during the query period	4,674,292	N/A	4,674,292	N/A	4,674,292	N/A	4,674,292	N/A	4,674,292	N/A
Had required coverage type (medical and/or drug coverage)	4,180,463	493,829	4,180,463	493,829	4,180,463	493,829	4,180,463	493,829	4,180,463	493,829
Enrolled during specified age range	4,180,301	162	4,180,301	162	4,180,301	162	4,180,301	162	4,180,301	162
Had requestable medical charts	4,180,301	0	4,180,301	0	4,180,301	0	4,180,301	0	4,180,301	0
Met demographic requirements (sex, race, and Hispanic origin)	4,180,127	174	4,180,127	174	4,180,127	174	4,180,127	174	4,180,127	174
Members with a valid index event										
Had any cohort-defining claim during the query period	*****	*****	2,470	4,177,657	396	4,179,731	*****	*****	127	4,180,000
Claim recorded during specified age range	*****	0	2,470	0	396	0	*****	0	127	0

Table 2. Summary of Patient-Level Cohort Attrition in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Amoxapine Dispensing from the Dispensing Table		Isoniazid Dispensing from the Dispensing Table		Atogepant Dispensing from the Dispensing Table		Inclisiran Dispensing from the Dispensing Table		Finerenone Dispensing from the Dispensing Table	
	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded
Episode defining index claim recorded during the query period	*****	*****	2,434	36	396	0	*****	0	127	0
Members with required pre-index history										
Had sufficient pre-index continuous enrollment	14	*****	1,389	1,045	303	93	*****	0	113	14
Met inclusion and exclusion criteria	14	0	1,389	0	303	0	*****	0	113	0
Met event incidence criteria	14	0	1,389	0	303	0	*****	0	113	0
Members with required post-index follow-up										
Had sufficient post-index continuous enrollment	14	0	1,389	0	303	0	*****	0	113	0
Had minimum days' supply on index date	14	0	1,389	0	303	0	*****	0	113	0
Had index episode of at least required length	14	0	1,389	0	303	0	*****	0	113	0
Had index episode longer than blackout period	14	0	1,389	0	303	0	*****	0	113	0

Table 2. Summary of Patient-Level Cohort Attrition in the Sentinel Distributed Database from January 1, 2016 to May 31, 2025

	Amoxapine Dispensing from the Dispensing Table		Isoniazid Dispensing from the Dispensing Table		Atogepant Dispensing from the Dispensing Table		Inclisiran Dispensing from the Dispensing Table		Finerenone Dispensing from the Dispensing Table	
	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded
Did not have an event during blackout period	14	0	1,389	0	303	0	*****	0	113	0
Final cohort										
Number of members	14	N/A	1,389	N/A	303	N/A	*****	N/A	113	N/A
Number of episodes	14	N/A	1,389	N/A	303	N/A	*****	N/A	113	N/A

*****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.

N/A: Not applicable

Sentinel

Appendix A. Dates of Available Data for Each Data Partner (DP) as of Request Distribution Date (November 7, 2025)

Masked DP ID	DP Start Date	DP End Date[1]
DP01	01/01/2004	05/31/2025
DP02	01/01/2000	04/30/2025
DP03	01/01/2000	04/30/2024

[1]End Date represents the earliest of: (1) query end date, or (2) last day of the most recent month for which all of a Data Partner's data tables (enrollment, dispensing, etc.) have at least 80% of the record count relative to the prior month.

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

Generic Name	Brand Name
Amoxapine	
amoxapine	Amoxapine
Isoniazid	
isoniazid	Isoniazid
rifampin/isoniazid	Rifamate
rifampin/isoniazid/pyrazinamide	Rifater
Atogepant	
atogepant	Qulipta
Inclisiran	
inclisiran sodium	Leqvio
Finerenone	
finerenone	Kerendia

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
	Acute myocardial infarction		
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery	Diagnosis	ICD-10-CM
I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery	Diagnosis	ICD-10-CM
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall	Diagnosis	ICD-10-CM
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery	Diagnosis	ICD-10-CM
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall	Diagnosis	ICD-10-CM
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery	Diagnosis	ICD-10-CM
I21.29	ST elevation (STEMI) myocardial infarction involving other sites	Diagnosis	ICD-10-CM
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site	Diagnosis	ICD-10-CM
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	Diagnosis	ICD-10-CM
I21.9	Acute myocardial infarction, unspecified	Diagnosis	ICD-10-CM
I21.A1	Myocardial infarction type 2	Diagnosis	ICD-10-CM
I21.A9	Other myocardial infarction type	Diagnosis	ICD-10-CM
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall	Diagnosis	ICD-10-CM
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall	Diagnosis	ICD-10-CM
I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction	Diagnosis	ICD-10-CM
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites	Diagnosis	ICD-10-CM
I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site	Diagnosis	ICD-10-CM
I23.0	Hemopericardium as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.1	Atrial septal defect as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.2	Ventricular septal defect as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.3	Rupture of cardiac wall without hemopericardium as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.4	Rupture of chordae tendineae as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.5	Rupture of papillary muscle as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.6	Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.7	Postinfarction angina	Diagnosis	ICD-10-CM
I23.8	Other current complications following acute myocardial infarction	Diagnosis	ICD-10-CM
	Alzheimer's disease		
F01.50	Vascular dementia without behavioral disturbance	Diagnosis	ICD-10-CM
F01.51	Vascular dementia with behavioral disturbance	Diagnosis	ICD-10-CM
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance	Diagnosis	ICD-10-CM
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance	Diagnosis	ICD-10-CM
F03.90	Unspecified dementia without behavioral disturbance	Diagnosis	ICD-10-CM

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Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
F03.91	Unspecified dementia with behavioral disturbance	Diagnosis	ICD-10-CM
F04	Amnestic disorder due to known physiological condition	Diagnosis	ICD-10-CM
F05	Delirium due to known physiological condition	Diagnosis	ICD-10-CM
F06.1	Catatonic disorder due to known physiological condition	Diagnosis	ICD-10-CM
F06.8	Other specified mental disorders due to known physiological condition	Diagnosis	ICD-10-CM
G13.8	Systemic atrophy primarily affecting central nervous system in other diseases classified elsewhere	Diagnosis	ICD-10-CM
G30.0	Alzheimer's disease with early onset	Diagnosis	ICD-10-CM
G30.1	Alzheimer's disease with late onset	Diagnosis	ICD-10-CM
G30.8	Other Alzheimer's disease	Diagnosis	ICD-10-CM
G30.9	Alzheimer's disease, unspecified	Diagnosis	ICD-10-CM
G31.01	Pick's disease	Diagnosis	ICD-10-CM
G31.09	Other frontotemporal dementia	Diagnosis	ICD-10-CM
G31.1	Senile degeneration of brain, not elsewhere classified	Diagnosis	ICD-10-CM
G31.2	Degeneration of nervous system due to alcohol	Diagnosis	ICD-10-CM
G94	Other disorders of brain in diseases classified elsewhere	Diagnosis	ICD-10-CM
R41.81	Age-related cognitive decline	Diagnosis	ICD-10-CM
R54	Age-related physical debility	Diagnosis	ICD-10-CM
	Anemia		
D50.0	Iron deficiency anemia secondary to blood loss (chronic)	Diagnosis	ICD-10-CM
D50.1	Sideropenic dysphagia	Diagnosis	ICD-10-CM
D50.8	Other iron deficiency anemias	Diagnosis	ICD-10-CM
D50.9	Iron deficiency anemia, unspecified	Diagnosis	ICD-10-CM
D51.0	Vitamin B12 deficiency anemia due to intrinsic factor deficiency	Diagnosis	ICD-10-CM
D51.1	Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria	Diagnosis	ICD-10-CM
D51.2	Transcobalamin II deficiency	Diagnosis	ICD-10-CM
D51.3	Other dietary vitamin B12 deficiency anemia	Diagnosis	ICD-10-CM
D51.8	Other vitamin B12 deficiency anemias	Diagnosis	ICD-10-CM
D51.9	Vitamin B12 deficiency anemia, unspecified	Diagnosis	ICD-10-CM
D52.0	Dietary folate deficiency anemia	Diagnosis	ICD-10-CM
D52.1	Drug-induced folate deficiency anemia	Diagnosis	ICD-10-CM
D52.8	Other folate deficiency anemias	Diagnosis	ICD-10-CM
D52.9	Folate deficiency anemia, unspecified	Diagnosis	ICD-10-CM
D53.0	Protein deficiency anemia	Diagnosis	ICD-10-CM
D53.1	Other megaloblastic anemias, not elsewhere classified	Diagnosis	ICD-10-CM
D53.2	Scorbutic anemia	Diagnosis	ICD-10-CM
D53.8	Other specified nutritional anemias	Diagnosis	ICD-10-CM
D53.9	Nutritional anemia, unspecified	Diagnosis	ICD-10-CM
D55.0	Anemia due to glucose-6-phosphate dehydrogenase [G6PD] deficiency	Diagnosis	ICD-10-CM
D55.1	Anemia due to other disorders of glutathione metabolism	Diagnosis	ICD-10-CM
D55.2	Anemia due to disorders of glycolytic enzymes	Diagnosis	ICD-10-CM
D55.3	Anemia due to disorders of nucleotide metabolism	Diagnosis	ICD-10-CM
D55.8	Other anemias due to enzyme disorders	Diagnosis	ICD-10-CM
D55.9	Anemia due to enzyme disorder, unspecified	Diagnosis	ICD-10-CM
D56.0	Alpha thalassemia	Diagnosis	ICD-10-CM
D56.1	Beta thalassemia	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
D56.2	Delta-beta thalassemia	Diagnosis	ICD-10-CM
D56.3	Thalassemia minor	Diagnosis	ICD-10-CM
D56.4	Hereditary persistence of fetal hemoglobin [HPFH]	Diagnosis	ICD-10-CM
D56.5	Hemoglobin E-beta thalassemia	Diagnosis	ICD-10-CM
D56.8	Other thalassemias	Diagnosis	ICD-10-CM
D56.9	Thalassemia, unspecified	Diagnosis	ICD-10-CM
D57.00	Hb-SS disease with crisis, unspecified	Diagnosis	ICD-10-CM
D57.01	Hb-SS disease with acute chest syndrome	Diagnosis	ICD-10-CM
D57.02	Hb-SS disease with splenic sequestration	Diagnosis	ICD-10-CM
D57.1	Sickle-cell disease without crisis	Diagnosis	ICD-10-CM
D57.20	Sickle-cell/Hb-C disease without crisis	Diagnosis	ICD-10-CM
D57.211	Sickle-cell/Hb-C disease with acute chest syndrome	Diagnosis	ICD-10-CM
D57.212	Sickle-cell/Hb-C disease with splenic sequestration	Diagnosis	ICD-10-CM
D57.219	Sickle-cell/Hb-C disease with crisis, unspecified	Diagnosis	ICD-10-CM
D57.3	Sickle-cell trait	Diagnosis	ICD-10-CM
D57.40	Sickle-cell thalassemia without crisis	Diagnosis	ICD-10-CM
D57.411	Sickle-cell thalassemia with acute chest syndrome	Diagnosis	ICD-10-CM
D57.412	Sickle-cell thalassemia with splenic sequestration	Diagnosis	ICD-10-CM
D57.419	Sickle-cell thalassemia with crisis, unspecified	Diagnosis	ICD-10-CM
D57.80	Other sickle-cell disorders without crisis	Diagnosis	ICD-10-CM
D57.811	Other sickle-cell disorders with acute chest syndrome	Diagnosis	ICD-10-CM
D57.812	Other sickle-cell disorders with splenic sequestration	Diagnosis	ICD-10-CM
D57.819	Other sickle-cell disorders with crisis, unspecified	Diagnosis	ICD-10-CM
D58.0	Hereditary spherocytosis	Diagnosis	ICD-10-CM
D58.1	Hereditary elliptocytosis	Diagnosis	ICD-10-CM
D58.2	Other hemoglobinopathies	Diagnosis	ICD-10-CM
D58.8	Other specified hereditary hemolytic anemias	Diagnosis	ICD-10-CM
D58.9	Hereditary hemolytic anemia, unspecified	Diagnosis	ICD-10-CM
D59.0	Drug-induced autoimmune hemolytic anemia	Diagnosis	ICD-10-CM
D59.1	Other autoimmune hemolytic anemias	Diagnosis	ICD-10-CM
D59.2	Drug-induced nonautoimmune hemolytic anemia	Diagnosis	ICD-10-CM
D59.3	Hemolytic-uremic syndrome	Diagnosis	ICD-10-CM
D59.4	Other nonautoimmune hemolytic anemias	Diagnosis	ICD-10-CM
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]	Diagnosis	ICD-10-CM
D59.6	Hemoglobinuria due to hemolysis from other external causes	Diagnosis	ICD-10-CM
D59.8	Other acquired hemolytic anemias	Diagnosis	ICD-10-CM
D59.9	Acquired hemolytic anemia, unspecified	Diagnosis	ICD-10-CM
D60.0	Chronic acquired pure red cell aplasia	Diagnosis	ICD-10-CM
D60.1	Transient acquired pure red cell aplasia	Diagnosis	ICD-10-CM
D60.8	Other acquired pure red cell aplasias	Diagnosis	ICD-10-CM
D60.9	Acquired pure red cell aplasia, unspecified	Diagnosis	ICD-10-CM
D61.01	Constitutional (pure) red blood cell aplasia	Diagnosis	ICD-10-CM
D61.09	Other constitutional aplastic anemia	Diagnosis	ICD-10-CM
D61.1	Drug-induced aplastic anemia	Diagnosis	ICD-10-CM
D61.2	Aplastic anemia due to other external agents	Diagnosis	ICD-10-CM
D61.3	Idiopathic aplastic anemia	Diagnosis	ICD-10-CM
D61.810	Antineoplastic chemotherapy induced pancytopenia	Diagnosis	ICD-10-CM

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Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
D61.811	Other drug-induced pancytopenia	Diagnosis	ICD-10-CM
D61.818	Other pancytopenia	Diagnosis	ICD-10-CM
D61.82	Myelophthisis	Diagnosis	ICD-10-CM
D61.89	Other specified aplastic anemias and other bone marrow failure	Diagnosis	ICD-10-CM
D61.9	Aplastic anemia, unspecified	Diagnosis	ICD-10-CM
D62	Acute posthemorrhagic anemia	Diagnosis	ICD-10-CM
D63.0	Anemia in neoplastic disease	Diagnosis	ICD-10-CM
D63.1	Anemia in chronic kidney disease	Diagnosis	ICD-10-CM
D63.8	Anemia in other chronic diseases classified elsewhere	Diagnosis	ICD-10-CM
D64.0	Hereditary sideroblastic anemia	Diagnosis	ICD-10-CM
D64.1	Secondary sideroblastic anemia due to disease	Diagnosis	ICD-10-CM
D64.2	Secondary sideroblastic anemia due to drugs and toxins	Diagnosis	ICD-10-CM
D64.3	Other sideroblastic anemias	Diagnosis	ICD-10-CM
D64.4	Congenital dyserythropoietic anemia	Diagnosis	ICD-10-CM
D64.81	Anemia due to antineoplastic chemotherapy	Diagnosis	ICD-10-CM
D64.89	Other specified anemias	Diagnosis	ICD-10-CM
D64.9	Anemia, unspecified	Diagnosis	ICD-10-CM
D57.03	Hb-SS disease with cerebral vascular involvement	Diagnosis	ICD-10-CM
D57.09	Hb-SS disease with crisis with other specified complication	Diagnosis	ICD-10-CM
D57.213	Sickle-cell/Hb-C disease with cerebral vascular involvement	Diagnosis	ICD-10-CM
D57.218	Sickle-cell/Hb-C disease with crisis with other specified complication	Diagnosis	ICD-10-CM
D57.413	Sickle-cell thalassemia, unspecified, with cerebral vascular involvement	Diagnosis	ICD-10-CM
D57.418	Sickle-cell thalassemia, unspecified, with crisis with other specified complication	Diagnosis	ICD-10-CM
D57.42	Sickle-cell thalassemia beta zero without crisis	Diagnosis	ICD-10-CM
D57.431	Sickle-cell thalassemia beta zero with acute chest syndrome	Diagnosis	ICD-10-CM
D57.432	Sickle-cell thalassemia beta zero with splenic sequestration	Diagnosis	ICD-10-CM
D57.433	Sickle-cell thalassemia beta zero with cerebral vascular involvement	Diagnosis	ICD-10-CM
D57.438	Sickle-cell thalassemia beta zero with crisis with other specified complication	Diagnosis	ICD-10-CM
D57.439	Sickle-cell thalassemia beta zero with crisis, unspecified	Diagnosis	ICD-10-CM
D57.44	Sickle-cell thalassemia beta plus without crisis	Diagnosis	ICD-10-CM
D57.451	Sickle-cell thalassemia beta plus with acute chest syndrome	Diagnosis	ICD-10-CM
D57.452	Sickle-cell thalassemia beta plus with splenic sequestration	Diagnosis	ICD-10-CM
D57.453	Sickle-cell thalassemia beta plus with cerebral vascular involvement	Diagnosis	ICD-10-CM
D57.458	Sickle-cell thalassemia beta plus with crisis with other specified complication	Diagnosis	ICD-10-CM
D57.459	Sickle-cell thalassemia beta plus with crisis, unspecified	Diagnosis	ICD-10-CM
D57.813	Other sickle-cell disorders with cerebral vascular involvement	Diagnosis	ICD-10-CM
D57.818	Other sickle-cell disorders with crisis with other specified complication	Diagnosis	ICD-10-CM
D59.10	Autoimmune hemolytic anemia, unspecified	Diagnosis	ICD-10-CM
D59.11	Warm autoimmune hemolytic anemia	Diagnosis	ICD-10-CM
D59.12	Cold autoimmune hemolytic anemia	Diagnosis	ICD-10-CM
D59.13	Mixed type autoimmune hemolytic anemia	Diagnosis	ICD-10-CM
D59.19	Other autoimmune hemolytic anemia	Diagnosis	ICD-10-CM
C94.6	Myelodysplastic disease, not elsewhere classified	Diagnosis	ICD-10-CM
D46.0	Refractory anemia without ring sideroblasts, so stated	Diagnosis	ICD-10-CM

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Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
D46.1	Refractory anemia with ring sideroblasts	Diagnosis	ICD-10-CM
D46.20	Refractory anemia with excess of blasts, unspecified	Diagnosis	ICD-10-CM
D46.21	Refractory anemia with excess of blasts 1	Diagnosis	ICD-10-CM
D46.22	Refractory anemia with excess of blasts 2	Diagnosis	ICD-10-CM
D46.4	Refractory anemia, unspecified	Diagnosis	ICD-10-CM
D46.9	Myelodysplastic syndrome, unspecified	Diagnosis	ICD-10-CM
D46.A	Refractory cytopenia with multilineage dysplasia	Diagnosis	ICD-10-CM
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts	Diagnosis	ICD-10-CM
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality	Diagnosis	ICD-10-CM
D46.Z	Other myelodysplastic syndromes	Diagnosis	ICD-10-CM
D47.4	Osteomyelofibrosis	Diagnosis	ICD-10-CM
D55.21	Anemia due to pyruvate kinase deficiency	Diagnosis	ICD-10-CM
D55.29	Anemia due to other disorders of glycolytic enzymes	Diagnosis	ICD-10-CM
D75.81	Myelofibrosis	Diagnosis	ICD-10-CM
	Asthma		
J45.20	Mild intermittent asthma, uncomplicated	Diagnosis	ICD-10-CM
J45.21	Mild intermittent asthma with (acute) exacerbation	Diagnosis	ICD-10-CM
J45.22	Mild intermittent asthma with status asthmaticus	Diagnosis	ICD-10-CM
J45.30	Mild persistent asthma, uncomplicated	Diagnosis	ICD-10-CM
J45.31	Mild persistent asthma with (acute) exacerbation	Diagnosis	ICD-10-CM
J45.32	Mild persistent asthma with status asthmaticus	Diagnosis	ICD-10-CM
J45.40	Moderate persistent asthma, uncomplicated	Diagnosis	ICD-10-CM
J45.41	Moderate persistent asthma with (acute) exacerbation	Diagnosis	ICD-10-CM
J45.42	Moderate persistent asthma with status asthmaticus	Diagnosis	ICD-10-CM
J45.50	Severe persistent asthma, uncomplicated	Diagnosis	ICD-10-CM
J45.51	Severe persistent asthma with (acute) exacerbation	Diagnosis	ICD-10-CM
J45.52	Severe persistent asthma with status asthmaticus	Diagnosis	ICD-10-CM
J45.901	Unspecified asthma with (acute) exacerbation	Diagnosis	ICD-10-CM
J45.902	Unspecified asthma with status asthmaticus	Diagnosis	ICD-10-CM
J45.909	Unspecified asthma, uncomplicated	Diagnosis	ICD-10-CM
J45.990	Exercise induced bronchospasm	Diagnosis	ICD-10-CM
J45.991	Cough variant asthma	Diagnosis	ICD-10-CM
J45.998	Other asthma	Diagnosis	ICD-10-CM
J82.83	Eosinophilic asthma	Diagnosis	ICD-10-CM
	Atrial fibrillation or flutter		
I48.2	Chronic atrial fibrillation		
I48.0	Paroxysmal atrial fibrillation	Diagnosis	ICD-10-CM
I48.1	Persistent atrial fibrillation	Diagnosis	ICD-10-CM
I48.91	Unspecified atrial fibrillation	Diagnosis	ICD-10-CM
I48.11	Longstanding persistent atrial fibrillation	Diagnosis	ICD-10-CM
I48.19	Other persistent atrial fibrillation	Diagnosis	ICD-10-CM
I48.20	Chronic atrial fibrillation, unspecified	Diagnosis	ICD-10-CM
I48.21	Permanent atrial fibrillation	Diagnosis	ICD-10-CM
I48.3	Typical atrial flutter	Diagnosis	ICD-10-CM
I48.4	Atypical atrial flutter	Diagnosis	ICD-10-CM
	Chronic kidney disease		
A18.11	Tuberculosis of kidney and ureter	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
A52.75	Syphilis of kidney and ureter	Diagnosis	ICD-10-CM
B52.0	Plasmodium malariae malaria with nephropathy	Diagnosis	ICD-10-CM
C64.1	Malignant neoplasm of right kidney, except renal pelvis	Diagnosis	ICD-10-CM
C64.2	Malignant neoplasm of left kidney, except renal pelvis	Diagnosis	ICD-10-CM
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis	Diagnosis	ICD-10-CM
C68.9	Malignant neoplasm of urinary organ, unspecified	Diagnosis	ICD-10-CM
D30.00	Benign neoplasm of unspecified kidney	Diagnosis	ICD-10-CM
D30.01	Benign neoplasm of right kidney	Diagnosis	ICD-10-CM
D30.02	Benign neoplasm of left kidney	Diagnosis	ICD-10-CM
D41.00	Neoplasm of uncertain behavior of unspecified kidney	Diagnosis	ICD-10-CM
D41.01	Neoplasm of uncertain behavior of right kidney	Diagnosis	ICD-10-CM
D41.02	Neoplasm of uncertain behavior of left kidney	Diagnosis	ICD-10-CM
D41.10	Neoplasm of uncertain behavior of unspecified renal pelvis	Diagnosis	ICD-10-CM
D41.11	Neoplasm of uncertain behavior of right renal pelvis	Diagnosis	ICD-10-CM
D41.12	Neoplasm of uncertain behavior of left renal pelvis	Diagnosis	ICD-10-CM
D41.20	Neoplasm of uncertain behavior of unspecified ureter	Diagnosis	ICD-10-CM
D41.21	Neoplasm of uncertain behavior of right ureter	Diagnosis	ICD-10-CM
D41.22	Neoplasm of uncertain behavior of left ureter	Diagnosis	ICD-10-CM
D59.3	Hemolytic-uremic syndrome	Diagnosis	ICD-10-CM
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy	Diagnosis	ICD-10-CM
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease	Diagnosis	ICD-10-CM
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication	Diagnosis	ICD-10-CM
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy	Diagnosis	ICD-10-CM
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease	Diagnosis	ICD-10-CM
E10.21	Type 1 diabetes mellitus with diabetic nephropathy	Diagnosis	ICD-10-CM
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	Diagnosis	ICD-10-CM
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication	Diagnosis	ICD-10-CM
E11.21	Type 2 diabetes mellitus with diabetic nephropathy	Diagnosis	ICD-10-CM
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	Diagnosis	ICD-10-CM
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication	Diagnosis	ICD-10-CM
E13.21	Other specified diabetes mellitus with diabetic nephropathy	Diagnosis	ICD-10-CM
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease	Diagnosis	ICD-10-CM
E13.29	Other specified diabetes mellitus with other diabetic kidney complication	Diagnosis	ICD-10-CM
E74.8	Other specified disorders of carbohydrate metabolism	Diagnosis	ICD-10-CM
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	Diagnosis	ICD-10-CM
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease	Diagnosis	ICD-10-CM
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	Diagnosis	ICD-10-CM
I70.1	Atherosclerosis of renal artery	Diagnosis	ICD-10-CM
I72.2	Aneurysm of renal artery	Diagnosis	ICD-10-CM
K76.7	Hepatorenal syndrome	Diagnosis	ICD-10-CM
M10.30	Gout due to renal impairment, unspecified site	Diagnosis	ICD-10-CM
M10.311	Gout due to renal impairment, right shoulder	Diagnosis	ICD-10-CM
M10.312	Gout due to renal impairment, left shoulder	Diagnosis	ICD-10-CM
M10.319	Gout due to renal impairment, unspecified shoulder	Diagnosis	ICD-10-CM
M10.321	Gout due to renal impairment, right elbow	Diagnosis	ICD-10-CM
M10.322	Gout due to renal impairment, left elbow	Diagnosis	ICD-10-CM
M10.329	Gout due to renal impairment, unspecified elbow	Diagnosis	ICD-10-CM
M10.331	Gout due to renal impairment, right wrist	Diagnosis	ICD-10-CM
M10.332	Gout due to renal impairment, left wrist	Diagnosis	ICD-10-CM
M10.339	Gout due to renal impairment, unspecified wrist	Diagnosis	ICD-10-CM
M10.341	Gout due to renal impairment, right hand	Diagnosis	ICD-10-CM
M10.342	Gout due to renal impairment, left hand	Diagnosis	ICD-10-CM
M10.349	Gout due to renal impairment, unspecified hand	Diagnosis	ICD-10-CM
M10.351	Gout due to renal impairment, right hip	Diagnosis	ICD-10-CM
M10.352	Gout due to renal impairment, left hip	Diagnosis	ICD-10-CM
M10.359	Gout due to renal impairment, unspecified hip	Diagnosis	ICD-10-CM
M10.361	Gout due to renal impairment, right knee	Diagnosis	ICD-10-CM
M10.362	Gout due to renal impairment, left knee	Diagnosis	ICD-10-CM
M10.369	Gout due to renal impairment, unspecified knee	Diagnosis	ICD-10-CM
M10.371	Gout due to renal impairment, right ankle and foot	Diagnosis	ICD-10-CM
M10.372	Gout due to renal impairment, left ankle and foot	Diagnosis	ICD-10-CM
M10.379	Gout due to renal impairment, unspecified ankle and foot	Diagnosis	ICD-10-CM
M10.38	Gout due to renal impairment, vertebrae	Diagnosis	ICD-10-CM
M10.39	Gout due to renal impairment, multiple sites	Diagnosis	ICD-10-CM
M32.14	Glomerular disease in systemic lupus erythematosus	Diagnosis	ICD-10-CM
M32.15	Tubulo-interstitial nephropathy in systemic lupus erythematosus	Diagnosis	ICD-10-CM
M35.04	Sicca syndrome with tubulo-interstitial nephropathy	Diagnosis	ICD-10-CM
N00.0	Acute nephritic syndrome with minor glomerular abnormality	Diagnosis	ICD-10-CM
N00.1	Acute nephritic syndrome with focal and segmental glomerular lesions	Diagnosis	ICD-10-CM
N00.2	Acute nephritic syndrome with diffuse membranous glomerulonephritis	Diagnosis	ICD-10-CM
N00.3	Acute nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N00.4	Acute nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N00.5	Acute nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	Diagnosis	ICD-10-CM
N00.6	Acute nephritic syndrome with dense deposit disease	Diagnosis	ICD-10-CM
N00.7	Acute nephritic syndrome with diffuse crescentic glomerulonephritis	Diagnosis	ICD-10-CM
N00.8	Acute nephritic syndrome with other morphologic changes	Diagnosis	ICD-10-CM
N00.9	Acute nephritic syndrome with unspecified morphologic changes	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
N01.0	Rapidly progressive nephritic syndrome with minor glomerular abnormality	Diagnosis	ICD-10-CM
N01.1	Rapidly progressive nephritic syndrome with focal and segmental glomerular lesions	Diagnosis	ICD-10-CM
N01.2	Rapidly progressive nephritic syndrome with diffuse membranous glomerulonephritis	Diagnosis	ICD-10-CM
N01.3	Rapidly progressive nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N01.4	Rapidly progressive nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N01.5	Rapidly progressive nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	Diagnosis	ICD-10-CM
N01.6	Rapidly progressive nephritic syndrome with dense deposit disease	Diagnosis	ICD-10-CM
N01.7	Rapidly progressive nephritic syndrome with diffuse crescentic glomerulonephritis	Diagnosis	ICD-10-CM
N01.8	Rapidly progressive nephritic syndrome with other morphologic changes	Diagnosis	ICD-10-CM
N01.9	Rapidly progressive nephritic syndrome with unspecified morphologic changes	Diagnosis	ICD-10-CM
N02.0	Recurrent and persistent hematuria with minor glomerular abnormality	Diagnosis	ICD-10-CM
N02.1	Recurrent and persistent hematuria with focal and segmental glomerular lesions	Diagnosis	ICD-10-CM
N02.2	Recurrent and persistent hematuria with diffuse membranous glomerulonephritis	Diagnosis	ICD-10-CM
N02.3	Recurrent and persistent hematuria with diffuse mesangial proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N02.4	Recurrent and persistent hematuria with diffuse endocapillary proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N02.5	Recurrent and persistent hematuria with diffuse mesangiocapillary glomerulonephritis	Diagnosis	ICD-10-CM
N02.6	Recurrent and persistent hematuria with dense deposit disease	Diagnosis	ICD-10-CM
N02.7	Recurrent and persistent hematuria with diffuse crescentic glomerulonephritis	Diagnosis	ICD-10-CM
N02.8	Recurrent and persistent hematuria with other morphologic changes	Diagnosis	ICD-10-CM
N02.9	Recurrent and persistent hematuria with unspecified morphologic changes	Diagnosis	ICD-10-CM
N03.0	Chronic nephritic syndrome with minor glomerular abnormality	Diagnosis	ICD-10-CM
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	Diagnosis	ICD-10-CM
N03.2	Chronic nephritic syndrome with diffuse membranous glomerulonephritis	Diagnosis	ICD-10-CM
N03.3	Chronic nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N03.4	Chronic nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N03.5	Chronic nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	Diagnosis	ICD-10-CM
N03.6	Chronic nephritic syndrome with dense deposit disease	Diagnosis	ICD-10-CM
N03.7	Chronic nephritic syndrome with diffuse crescentic glomerulonephritis	Diagnosis	ICD-10-CM
N03.8	Chronic nephritic syndrome with other morphologic changes	Diagnosis	ICD-10-CM
N03.9	Chronic nephritic syndrome with unspecified morphologic changes	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
N04.0	Nephrotic syndrome with minor glomerular abnormality	Diagnosis	ICD-10-CM
N04.1	Nephrotic syndrome with focal and segmental glomerular lesions	Diagnosis	ICD-10-CM
N04.2	Nephrotic syndrome with diffuse membranous glomerulonephritis	Diagnosis	ICD-10-CM
N04.3	Nephrotic syndrome with diffuse mesangial proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N04.4	Nephrotic syndrome with diffuse endocapillary proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N04.5	Nephrotic syndrome with diffuse mesangiocapillary glomerulonephritis	Diagnosis	ICD-10-CM
N04.6	Nephrotic syndrome with dense deposit disease	Diagnosis	ICD-10-CM
N04.7	Nephrotic syndrome with diffuse crescentic glomerulonephritis	Diagnosis	ICD-10-CM
N04.8	Nephrotic syndrome with other morphologic changes	Diagnosis	ICD-10-CM
N04.9	Nephrotic syndrome with unspecified morphologic changes	Diagnosis	ICD-10-CM
N05.0	Unspecified nephritic syndrome with minor glomerular abnormality	Diagnosis	ICD-10-CM
N05.1	Unspecified nephritic syndrome with focal and segmental glomerular lesions	Diagnosis	ICD-10-CM
N05.2	Unspecified nephritic syndrome with diffuse membranous glomerulonephritis	Diagnosis	ICD-10-CM
N05.3	Unspecified nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N05.4	Unspecified nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N05.5	Unspecified nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	Diagnosis	ICD-10-CM
N05.6	Unspecified nephritic syndrome with dense deposit disease	Diagnosis	ICD-10-CM
N05.7	Unspecified nephritic syndrome with diffuse crescentic glomerulonephritis	Diagnosis	ICD-10-CM
N05.8	Unspecified nephritic syndrome with other morphologic changes	Diagnosis	ICD-10-CM
N05.9	Unspecified nephritic syndrome with unspecified morphologic changes	Diagnosis	ICD-10-CM
N06.0	Isolated proteinuria with minor glomerular abnormality	Diagnosis	ICD-10-CM
N06.1	Isolated proteinuria with focal and segmental glomerular lesions	Diagnosis	ICD-10-CM
N06.2	Isolated proteinuria with diffuse membranous glomerulonephritis	Diagnosis	ICD-10-CM
N06.3	Isolated proteinuria with diffuse mesangial proliferative	Diagnosis	ICD-10-CM
N06.4	Isolated proteinuria with diffuse endocapillary proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N06.5	Isolated proteinuria with diffuse mesangiocapillary glomerulonephritis	Diagnosis	ICD-10-CM
N06.6	Isolated proteinuria with dense deposit disease	Diagnosis	ICD-10-CM
N06.7	Isolated proteinuria with diffuse crescentic glomerulonephritis	Diagnosis	ICD-10-CM
N06.8	Isolated proteinuria with other morphologic lesion	Diagnosis	ICD-10-CM
N06.9	Isolated proteinuria with unspecified morphologic lesion	Diagnosis	ICD-10-CM
N07.0	Hereditary nephropathy, not elsewhere classified with minor glomerular abnormality	Diagnosis	ICD-10-CM
N07.1	Hereditary nephropathy, not elsewhere classified with focal and segmental glomerular lesions	Diagnosis	ICD-10-CM
N07.2	Hereditary nephropathy, not elsewhere classified with diffuse membranous glomerulonephritis	Diagnosis	ICD-10-CM
N07.3	Hereditary nephropathy, not elsewhere classified with diffuse mesangial proliferative glomerulonephritis	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
N07.4	Hereditary nephropathy, not elsewhere classified with diffuse endocapillary proliferative glomerulonephritis	Diagnosis	ICD-10-CM
N07.5	Hereditary nephropathy, not elsewhere classified with diffuse mesangiocapillary glomerulonephritis	Diagnosis	ICD-10-CM
N07.6	Hereditary nephropathy, not elsewhere classified with dense deposit disease	Diagnosis	ICD-10-CM
N07.7	Hereditary nephropathy, not elsewhere classified with diffuse crescentic glomerulonephritis	Diagnosis	ICD-10-CM
N07.8	Hereditary nephropathy, not elsewhere classified with other morphologic lesions	Diagnosis	ICD-10-CM
N07.9	Hereditary nephropathy, not elsewhere classified with unspecified morphologic lesions	Diagnosis	ICD-10-CM
N08	Glomerular disorders in diseases classified elsewhere	Diagnosis	ICD-10-CM
N13.1	Hydronephrosis with ureteral stricture, not elsewhere classified	Diagnosis	ICD-10-CM
N13.2	Hydronephrosis with renal and ureteral calculous obstruction	Diagnosis	ICD-10-CM
N13.30	Unspecified hydronephrosis	Diagnosis	ICD-10-CM
N13.39	Other hydronephrosis	Diagnosis	ICD-10-CM
N14.0	Analgesic nephropathy	Diagnosis	ICD-10-CM
N14.1	Nephropathy induced by other drugs, medicaments and biological substances	Diagnosis	ICD-10-CM
N14.2	Nephropathy induced by unspecified drug, medicament or biological substance	Diagnosis	ICD-10-CM
N14.3	Nephropathy induced by heavy metals	Diagnosis	ICD-10-CM
N14.4	Toxic nephropathy, not elsewhere classified	Diagnosis	ICD-10-CM
N15.0	Balkan nephropathy	Diagnosis	ICD-10-CM
N15.8	Other specified renal tubulo-interstitial diseases	Diagnosis	ICD-10-CM
N15.9	Renal tubulo-interstitial disease, unspecified	Diagnosis	ICD-10-CM
N16	Renal tubulo-interstitial disorders in diseases classified elsewhere	Diagnosis	ICD-10-CM
N17.0	Acute kidney failure with tubular necrosis	Diagnosis	ICD-10-CM
N17.1	Acute kidney failure with acute cortical necrosis	Diagnosis	ICD-10-CM
N17.2	Acute kidney failure with medullary necrosis	Diagnosis	ICD-10-CM
N17.8	Other acute kidney failure	Diagnosis	ICD-10-CM
N17.9	Acute kidney failure, unspecified	Diagnosis	ICD-10-CM
N18.1	Chronic kidney disease, stage 1	Diagnosis	ICD-10-CM
N18.2	Chronic kidney disease, stage 2 (mild)	Diagnosis	ICD-10-CM
N18.3	Chronic kidney disease, stage 3 (moderate)	Diagnosis	ICD-10-CM
N18.4	Chronic kidney disease, stage 4 (severe)	Diagnosis	ICD-10-CM
N18.5	Chronic kidney disease, stage 5	Diagnosis	ICD-10-CM
N18.6	End stage renal disease	Diagnosis	ICD-10-CM
N18.9	Chronic kidney disease, unspecified	Diagnosis	ICD-10-CM
N19	Unspecified kidney failure	Diagnosis	ICD-10-CM
N25.0	Renal osteodystrophy	Diagnosis	ICD-10-CM
N25.1	Nephrogenic diabetes insipidus	Diagnosis	ICD-10-CM
N25.81	Secondary hyperparathyroidism of renal origin	Diagnosis	ICD-10-CM
N25.89	Other disorders resulting from impaired renal tubular function	Diagnosis	ICD-10-CM
N25.9	Disorder resulting from impaired renal tubular function, unspecified	Diagnosis	ICD-10-CM
N26.1	Atrophy of kidney (terminal)	Diagnosis	ICD-10-CM

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Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
N26.9	Renal sclerosis, unspecified	Diagnosis	ICD-10-CM
Q61.02	Congenital multiple renal cysts	Diagnosis	ICD-10-CM
Q61.11	Cystic dilatation of collecting ducts	Diagnosis	ICD-10-CM
Q61.19	Other polycystic kidney, infantile type	Diagnosis	ICD-10-CM
Q61.2	Polycystic kidney, adult type	Diagnosis	ICD-10-CM
Q61.3	Polycystic kidney, unspecified	Diagnosis	ICD-10-CM
Q61.4	Renal dysplasia	Diagnosis	ICD-10-CM
Q61.5	Medullary cystic kidney	Diagnosis	ICD-10-CM
Q61.8	Other cystic kidney diseases	Diagnosis	ICD-10-CM
Q62.0	Congenital hydronephrosis	Diagnosis	ICD-10-CM
Q62.10	Congenital occlusion of ureter, unspecified	Diagnosis	ICD-10-CM
Q62.11	Congenital occlusion of ureteropelvic junction	Diagnosis	ICD-10-CM
Q62.12	Congenital occlusion of ureterovesical orifice	Diagnosis	ICD-10-CM
Q62.2	Congenital megaureter	Diagnosis	ICD-10-CM
Q62.31	Congenital ureterocele, orthotopic	Diagnosis	ICD-10-CM
Q62.32	Cecoureterocele	Diagnosis	ICD-10-CM
Q62.39	Other obstructive defects of renal pelvis and ureter	Diagnosis	ICD-10-CM
R94.4	Abnormal results of kidney function studies	Diagnosis	ICD-10-CM
N00.A	Acute nephritic syndrome with C3 glomerulonephritis	Diagnosis	ICD-10-CM
N01.A	Rapidly progressive nephritic syndrome with C3 glomerulonephritis	Diagnosis	ICD-10-CM
N02.A	Recurrent and persistent hematuria with C3 glomerulonephritis	Diagnosis	ICD-10-CM
N03.A	Chronic nephritic syndrome with C3 glomerulonephritis	Diagnosis	ICD-10-CM
N04.A	Nephrotic syndrome with C3 glomerulonephritis	Diagnosis	ICD-10-CM
N05.A	Unspecified nephritic syndrome with C3 glomerulonephritis	Diagnosis	ICD-10-CM
N06.A	Isolated proteinuria with C3 glomerulonephritis	Diagnosis	ICD-10-CM
N07.A	Hereditary nephropathy, not elsewhere classified with C3 glomerulonephritis	Diagnosis	ICD-10-CM
N18.30	Chronic kidney disease, stage 3 unspecified	Diagnosis	ICD-10-CM
N18.31	Chronic kidney disease, stage 3a	Diagnosis	ICD-10-CM
N18.32	Chronic kidney disease, stage 3b	Diagnosis	ICD-10-CM
M35.0A	Sjogren syndrome with glomerular disease	Diagnosis	ICD-10-CM
N99.0	Postprocedural (acute) (chronic) kidney failure	Diagnosis	ICD-10-CM
	Chronic obstructive pulmonary disease		
E88.81	Metabolic syndrome and other insulin resistance	Diagnosis	ICD-10-CM
J40	Bronchitis, not specified as acute or chronic	Diagnosis	ICD-10-CM
J41.0	Simple chronic bronchitis	Diagnosis	ICD-10-CM
J41.1	Mucopurulent chronic bronchitis	Diagnosis	ICD-10-CM
J41.8	Mixed simple and mucopurulent chronic bronchitis	Diagnosis	ICD-10-CM
J42	Unspecified chronic bronchitis	Diagnosis	ICD-10-CM
J43.0	Unilateral pulmonary emphysema [MacLeod's syndrome]	Diagnosis	ICD-10-CM
J43.1	Panlobular emphysema	Diagnosis	ICD-10-CM
J43.2	Centrilobular emphysema	Diagnosis	ICD-10-CM
J43.8	Other emphysema	Diagnosis	ICD-10-CM
J43.9	Emphysema, unspecified	Diagnosis	ICD-10-CM
J44.0	Chronic obstructive pulmonary disease with acute lower respiratory infection	Diagnosis	ICD-10-CM
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
J44.9	Chronic obstructive pulmonary disease, unspecified	Diagnosis	ICD-10-CM
J47.0	Bronchiectasis with acute lower respiratory infection	Diagnosis	ICD-10-CM
J47.1	Bronchiectasis with (acute) exacerbation	Diagnosis	ICD-10-CM
J47.9	Bronchiectasis, uncomplicated	Diagnosis	ICD-10-CM
J98.2	Interstitial emphysema	Diagnosis	ICD-10-CM
J98.3	Compensatory emphysema	Diagnosis	ICD-10-CM
Bipolar or other depressive mood disorders			
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified	Diagnosis	ICD-10-CM
F31.31	Bipolar disorder, current episode depressed, mild	Diagnosis	ICD-10-CM
F31.32	Bipolar disorder, current episode depressed, moderate	Diagnosis	ICD-10-CM
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features	Diagnosis	ICD-10-CM
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features	Diagnosis	ICD-10-CM
F31.60	Bipolar disorder, current episode mixed, unspecified	Diagnosis	ICD-10-CM
F31.61	Bipolar disorder, current episode mixed, mild	Diagnosis	ICD-10-CM
F31.62	Bipolar disorder, current episode mixed, moderate	Diagnosis	ICD-10-CM
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic	Diagnosis	ICD-10-CM
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features	Diagnosis	ICD-10-CM
F31.75	Bipolar disorder, in partial remission, most recent episode depressed	Diagnosis	ICD-10-CM
F31.76	Bipolar disorder, in full remission, most recent episode depressed	Diagnosis	ICD-10-CM
F31.77	Bipolar disorder, in partial remission, most recent episode mixed	Diagnosis	ICD-10-CM
F31.78	Bipolar disorder, in full remission, most recent episode mixed	Diagnosis	ICD-10-CM
F31.81	Bipolar II disorder	Diagnosis	ICD-10-CM
F32.0	Major depressive disorder, single episode, mild	Diagnosis	ICD-10-CM
F32.1	Major depressive disorder, single episode, moderate	Diagnosis	ICD-10-CM
F32.2	Major depressive disorder, single episode, severe without psychotic features	Diagnosis	ICD-10-CM
F32.3	Major depressive disorder, single episode, severe with psychotic features	Diagnosis	ICD-10-CM
F32.4	Major depressive disorder, single episode, in partial remission	Diagnosis	ICD-10-CM
F32.5	Major depressive disorder, single episode, in full remission	Diagnosis	ICD-10-CM
F32.9	Major depressive disorder, single episode, unspecified	Diagnosis	ICD-10-CM
F33.0	Major depressive disorder, recurrent, mild	Diagnosis	ICD-10-CM
F33.1	Major depressive disorder, recurrent, moderate	Diagnosis	ICD-10-CM
F33.2	Major depressive disorder, recurrent severe without psychotic features	Diagnosis	ICD-10-CM
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	Diagnosis	ICD-10-CM
F33.40	Major depressive disorder, recurrent, in remission, unspecified	Diagnosis	ICD-10-CM
F33.41	Major depressive disorder, recurrent, in partial remission	Diagnosis	ICD-10-CM
F33.42	Major depressive disorder, recurrent, in full remission	Diagnosis	ICD-10-CM
F33.8	Other recurrent depressive disorders	Diagnosis	ICD-10-CM
F33.9	Major depressive disorder, recurrent, unspecified	Diagnosis	ICD-10-CM
F34.1	Dysthymic disorder	Diagnosis	ICD-10-CM
F43.21	Adjustment disorder with depressed mood	Diagnosis	ICD-10-CM
F43.23	Adjustment disorder with mixed anxiety and depressed mood	Diagnosis	ICD-10-CM
F06.31	Mood disorder due to known physiological condition with depressive features	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
F06.32	Mood disorder due to known physiological condition with major depressive-like episode	Diagnosis	ICD-10-CM
F31.0	Bipolar disorder, current episode hypomanic	Diagnosis	ICD-10-CM
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified	Diagnosis	ICD-10-CM
F31.11	Bipolar disorder, current episode manic without psychotic features, mild	Diagnosis	ICD-10-CM
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate	Diagnosis	ICD-10-CM
F31.13	Bipolar disorder, current episode manic without psychotic features, severe	Diagnosis	ICD-10-CM
F31.2	Bipolar disorder, current episode manic severe with psychotic features	Diagnosis	ICD-10-CM
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic	Diagnosis	ICD-10-CM
F31.73	Bipolar disorder, in partial remission, most recent episode manic	Diagnosis	ICD-10-CM
F31.89	Other bipolar disorder	Diagnosis	ICD-10-CM
F31.9	Bipolar disorder, unspecified	Diagnosis	ICD-10-CM
F32.8	Other depressive episodes	Diagnosis	ICD-10-CM
F32.89	Other specified depressive episodes	Diagnosis	ICD-10-CM
F32.A	Depression, unspecified	Diagnosis	ICD-10-CM
F34.0	Cyclothymic disorder	Diagnosis	ICD-10-CM
	Diabetes		
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	Diagnosis	ICD-10-CM
E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma	Diagnosis	ICD-10-CM
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma	Diagnosis	ICD-10-CM
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma	Diagnosis	ICD-10-CM
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy	Diagnosis	ICD-10-CM
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease	Diagnosis	ICD-10-CM
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication	Diagnosis	ICD-10-CM
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E08.321	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E08.3219	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E08.329	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM

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Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E08.3291	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E08.3292	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E08.3293	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E08.3299	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E08.331	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E08.3319	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E08.339	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E08.3391	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E08.3392	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E08.3393	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E08.3399	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E08.341	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E08.3419	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E08.349	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E08.3491	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E08.3492	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E08.3493	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E08.3499	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E08.351	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E08.3519	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	Diagnosis	ICD-10-CM
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	Diagnosis	ICD-10-CM
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	Diagnosis	ICD-10-CM
E08.3529	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	Diagnosis	ICD-10-CM
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	Diagnosis	ICD-10-CM
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	Diagnosis	ICD-10-CM
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	Diagnosis	ICD-10-CM
E08.3539	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	Diagnosis	ICD-10-CM
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	Diagnosis	ICD-10-CM
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	Diagnosis	ICD-10-CM
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	Diagnosis	ICD-10-CM
E08.3549	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye	Diagnosis	ICD-10-CM
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye	Diagnosis	ICD-10-CM
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral	Diagnosis	ICD-10-CM
E08.3559	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, unspecified eye	Diagnosis	ICD-10-CM
E08.359	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E08.3599	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract	Diagnosis	ICD-10-CM
E08.37X1	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, right eye	Diagnosis	ICD-10-CM
E08.37X2	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, left eye	Diagnosis	ICD-10-CM
E08.37X3	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, bilateral	Diagnosis	ICD-10-CM
E08.37X9	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, unspecified eye	Diagnosis	ICD-10-CM
E08.39	Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication	Diagnosis	ICD-10-CM
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified	Diagnosis	ICD-10-CM
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy	Diagnosis	ICD-10-CM
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy	Diagnosis	ICD-10-CM
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy	Diagnosis	ICD-10-CM
E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy	Diagnosis	ICD-10-CM
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication	Diagnosis	ICD-10-CM
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene	Diagnosis	ICD-10-CM
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene	Diagnosis	ICD-10-CM
E08.59	Diabetes mellitus due to underlying condition with other circulatory complications	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

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

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E09.3219	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E09.329	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E09.3291	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E09.3292	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E09.3293	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E09.3299	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E09.331	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E09.3311	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E09.3312	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E09.3313	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E09.3319	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E09.339	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E09.3391	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E09.3392	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E09.3393	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E09.3399	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified	Diagnosis	ICD-10-CM
E09.341	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E09.3411	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E09.3412	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E09.3413	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E09.3419	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E09.349	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E09.3491	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

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

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E09.3543	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	Diagnosis	ICD-10-CM
E09.3549	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	Diagnosis	ICD-10-CM
E09.3551	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, right eye	Diagnosis	ICD-10-CM
E09.3552	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, left eye	Diagnosis	ICD-10-CM
E09.3553	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	Diagnosis	ICD-10-CM
E09.3559	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	Diagnosis	ICD-10-CM
E09.359	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E09.3591	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E09.3592	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E09.3593	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E09.3599	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract	Diagnosis	ICD-10-CM
E09.37X1	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	Diagnosis	ICD-10-CM
E09.37X2	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, left eye	Diagnosis	ICD-10-CM
E09.37X3	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	Diagnosis	ICD-10-CM
E09.37X9	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	Diagnosis	ICD-10-CM
E09.39	Drug or chemical induced diabetes mellitus with other diabetic ophthalmic complication	Diagnosis	ICD-10-CM
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified	Diagnosis	ICD-10-CM
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy	Diagnosis	ICD-10-CM
E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy	Diagnosis	ICD-10-CM
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy	Diagnosis	ICD-10-CM
E09.44	Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy	Diagnosis	ICD-10-CM
E09.49	Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene	Diagnosis	ICD-10-CM
E09.52	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene	Diagnosis	ICD-10-CM
E09.59	Drug or chemical induced diabetes mellitus with other circulatory complications	Diagnosis	ICD-10-CM
E09.610	Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy	Diagnosis	ICD-10-CM
E09.618	Drug or chemical induced diabetes mellitus with other diabetic	Diagnosis	ICD-10-CM
E09.620	Drug or chemical induced diabetes mellitus with diabetic dermatitis	Diagnosis	ICD-10-CM
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer	Diagnosis	ICD-10-CM
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer	Diagnosis	ICD-10-CM
E09.628	Drug or chemical induced diabetes mellitus with other skin complications	Diagnosis	ICD-10-CM
E09.630	Drug or chemical induced diabetes mellitus with periodontal disease	Diagnosis	ICD-10-CM
E09.638	Drug or chemical induced diabetes mellitus with other oral complications	Diagnosis	ICD-10-CM
E09.641	Drug or chemical induced diabetes mellitus with hypoglycemia with coma	Diagnosis	ICD-10-CM
E09.649	Drug or chemical induced diabetes mellitus with hypoglycemia without coma	Diagnosis	ICD-10-CM
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia	Diagnosis	ICD-10-CM
E09.69	Drug or chemical induced diabetes mellitus with other specified complication	Diagnosis	ICD-10-CM
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications	Diagnosis	ICD-10-CM
E09.9	Drug or chemical induced diabetes mellitus without complications	Diagnosis	ICD-10-CM
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma	Diagnosis	ICD-10-CM
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma	Diagnosis	ICD-10-CM
E10.21	Type 1 diabetes mellitus with diabetic nephropathy	Diagnosis	ICD-10-CM
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	Diagnosis	ICD-10-CM
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication	Diagnosis	ICD-10-CM
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E10.321	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E10.3219	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E10.329	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E10.3291	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E10.3292	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E10.3293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E10.3299	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E10.331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E10.3319	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E10.339	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E10.3391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E10.3392	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E10.3393	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E10.3399	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E10.341	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E10.3419	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E10.349	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E10.3493	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E10.3499	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E10.351	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E10.3519	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E10.359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E10.36	Type 1 diabetes mellitus with diabetic cataract	Diagnosis	ICD-10-CM
E10.37X1	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	Diagnosis	ICD-10-CM
E10.37X2	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye	Diagnosis	ICD-10-CM
E10.37X3	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	Diagnosis	ICD-10-CM
E10.37X9	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	Diagnosis	ICD-10-CM
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication	Diagnosis	ICD-10-CM
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified	Diagnosis	ICD-10-CM
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy	Diagnosis	ICD-10-CM
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy	Diagnosis	ICD-10-CM
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy	Diagnosis	ICD-10-CM
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy	Diagnosis	ICD-10-CM
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication	Diagnosis	ICD-10-CM
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene	Diagnosis	ICD-10-CM
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with	Diagnosis	ICD-10-CM
E10.59	Type 1 diabetes mellitus with other circulatory complications	Diagnosis	ICD-10-CM
E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy	Diagnosis	ICD-10-CM
E10.618	Type 1 diabetes mellitus with other diabetic arthropathy	Diagnosis	ICD-10-CM
E10.620	Type 1 diabetes mellitus with diabetic dermatitis	Diagnosis	ICD-10-CM
E10.621	Type 1 diabetes mellitus with foot ulcer	Diagnosis	ICD-10-CM
E10.622	Type 1 diabetes mellitus with other skin ulcer	Diagnosis	ICD-10-CM
E10.628	Type 1 diabetes mellitus with other skin complications	Diagnosis	ICD-10-CM
E10.630	Type 1 diabetes mellitus with periodontal disease	Diagnosis	ICD-10-CM
E10.638	Type 1 diabetes mellitus with other oral complications	Diagnosis	ICD-10-CM
E10.641	Type 1 diabetes mellitus with hypoglycemia with coma	Diagnosis	ICD-10-CM
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma	Diagnosis	ICD-10-CM
E10.65	Type 1 diabetes mellitus with hyperglycemia	Diagnosis	ICD-10-CM
E10.69	Type 1 diabetes mellitus with other specified complication	Diagnosis	ICD-10-CM
E10.8	Type 1 diabetes mellitus with unspecified complications	Diagnosis	ICD-10-CM
E10.9	Type 1 diabetes mellitus without complications	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	Diagnosis	ICD-10-CM
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma	Diagnosis	ICD-10-CM
E11.10	Type 2 diabetes mellitus with ketoacidosis without coma	Diagnosis	ICD-10-CM
E11.11	Type 2 diabetes mellitus with ketoacidosis with coma	Diagnosis	ICD-10-CM
E11.21	Type 2 diabetes mellitus with diabetic nephropathy	Diagnosis	ICD-10-CM
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	Diagnosis	ICD-10-CM
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication	Diagnosis	ICD-10-CM
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E11.321	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E11.3219	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E11.3291	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E11.3293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E11.3299	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E11.3319	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E11.3392	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E11.3393	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E11.3399	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E11.3419	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E11.3491	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E11.3492	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E11.3493	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E11.3499	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E11.351	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E11.3519	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	Diagnosis	ICD-10-CM
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	Diagnosis	ICD-10-CM
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	Diagnosis	ICD-10-CM
E11.3529	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	Diagnosis	ICD-10-CM
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	Diagnosis	ICD-10-CM
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	Diagnosis	ICD-10-CM
E11.3539	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	Diagnosis	ICD-10-CM
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	Diagnosis	ICD-10-CM
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	Diagnosis	ICD-10-CM
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	Diagnosis	ICD-10-CM
E11.3549	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	Diagnosis	ICD-10-CM
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	Diagnosis	ICD-10-CM
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	Diagnosis	ICD-10-CM
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	Diagnosis	ICD-10-CM
E11.3559	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	Diagnosis	ICD-10-CM
E11.359	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E11.3599	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E11.36	Type 2 diabetes mellitus with diabetic cataract	Diagnosis	ICD-10-CM
E11.37X1	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	Diagnosis	ICD-10-CM
E11.37X2	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye	Diagnosis	ICD-10-CM
E11.37X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	Diagnosis	ICD-10-CM
E11.37X9	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	Diagnosis	ICD-10-CM
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication	Diagnosis	ICD-10-CM
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy	Diagnosis	ICD-10-CM
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	Diagnosis	ICD-10-CM
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy	Diagnosis	ICD-10-CM
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy	Diagnosis	ICD-10-CM
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication	Diagnosis	ICD-10-CM
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	Diagnosis	ICD-10-CM
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with	Diagnosis	ICD-10-CM
E11.59	Type 2 diabetes mellitus with other circulatory complications	Diagnosis	ICD-10-CM
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy	Diagnosis	ICD-10-CM
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy	Diagnosis	ICD-10-CM
E11.620	Type 2 diabetes mellitus with diabetic dermatitis	Diagnosis	ICD-10-CM
E11.621	Type 2 diabetes mellitus with foot ulcer	Diagnosis	ICD-10-CM
E11.622	Type 2 diabetes mellitus with other skin ulcer	Diagnosis	ICD-10-CM
E11.628	Type 2 diabetes mellitus with other skin complications	Diagnosis	ICD-10-CM
E11.630	Type 2 diabetes mellitus with periodontal disease	Diagnosis	ICD-10-CM
E11.638	Type 2 diabetes mellitus with other oral complications	Diagnosis	ICD-10-CM
E11.641	Type 2 diabetes mellitus with hypoglycemia with coma	Diagnosis	ICD-10-CM
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma	Diagnosis	ICD-10-CM
E11.65	Type 2 diabetes mellitus with hyperglycemia	Diagnosis	ICD-10-CM
E11.69	Type 2 diabetes mellitus with other specified complication	Diagnosis	ICD-10-CM
E11.8	Type 2 diabetes mellitus with unspecified complications	Diagnosis	ICD-10-CM
E11.9	Type 2 diabetes mellitus without complications	Diagnosis	ICD-10-CM
E13.00	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	Diagnosis	ICD-10-CM
E13.01	Other specified diabetes mellitus with hyperosmolarity with coma	Diagnosis	ICD-10-CM
E13.10	Other specified diabetes mellitus with ketoacidosis without coma	Diagnosis	ICD-10-CM
E13.11	Other specified diabetes mellitus with ketoacidosis with coma	Diagnosis	ICD-10-CM
E13.21	Other specified diabetes mellitus with diabetic nephropathy	Diagnosis	ICD-10-CM
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease	Diagnosis	ICD-10-CM
E13.29	Other specified diabetes mellitus with other diabetic kidney complication	Diagnosis	ICD-10-CM
E13.311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E13.319	Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E13.321	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E13.3211	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E13.3212	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E13.3213	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E13.3219	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E13.329	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E13.3291	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E13.3292	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E13.3293	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E13.3299	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E13.331	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E13.3311	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E13.3312	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E13.3313	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E13.3319	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E13.339	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E13.3391	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E13.3392	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E13.3393	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E13.3399	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E13.341	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E13.3411	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E13.3412	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E13.3413	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E13.3419	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E13.349	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E13.3491	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E13.3492	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E13.3493	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM

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Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E13.3499	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E13.351	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema	Diagnosis	ICD-10-CM
E13.3511	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	Diagnosis	ICD-10-CM
E13.3512	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	Diagnosis	ICD-10-CM
E13.3513	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	Diagnosis	ICD-10-CM
E13.3519	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	Diagnosis	ICD-10-CM
E13.3521	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	Diagnosis	ICD-10-CM
E13.3522	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	Diagnosis	ICD-10-CM
E13.3523	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	Diagnosis	ICD-10-CM
E13.3529	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	Diagnosis	ICD-10-CM
E13.3531	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	Diagnosis	ICD-10-CM
E13.3532	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	Diagnosis	ICD-10-CM
E13.3533	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	Diagnosis	ICD-10-CM
E13.3539	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	Diagnosis	ICD-10-CM
E13.3541	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	Diagnosis	ICD-10-CM
E13.3542	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	Diagnosis	ICD-10-CM
E13.3543	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	Diagnosis	ICD-10-CM
E13.3549	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	Diagnosis	ICD-10-CM
E13.3551	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, right eye	Diagnosis	ICD-10-CM
E13.3552	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, left eye	Diagnosis	ICD-10-CM
E13.3553	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E13.3559	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	Diagnosis	ICD-10-CM
E13.359	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema	Diagnosis	ICD-10-CM
E13.36	Other specified diabetes mellitus with diabetic cataract	Diagnosis	ICD-10-CM
E13.39	Other specified diabetes mellitus with other diabetic ophthalmic complication	Diagnosis	ICD-10-CM
E13.40	Other specified diabetes mellitus with diabetic neuropathy, unspecified	Diagnosis	ICD-10-CM
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy	Diagnosis	ICD-10-CM
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy	Diagnosis	ICD-10-CM
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy	Diagnosis	ICD-10-CM
E13.44	Other specified diabetes mellitus with diabetic amyotrophy	Diagnosis	ICD-10-CM
E13.49	Other specified diabetes mellitus with other diabetic neurological complication	Diagnosis	ICD-10-CM
E13.51	Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene	Diagnosis	ICD-10-CM
E13.52	Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene	Diagnosis	ICD-10-CM
E13.59	Other specified diabetes mellitus with other circulatory complications	Diagnosis	ICD-10-CM
E13.610	Other specified diabetes mellitus with diabetic neuropathic arthropathy	Diagnosis	ICD-10-CM
E13.618	Other specified diabetes mellitus with other diabetic arthropathy	Diagnosis	ICD-10-CM
E13.620	Other specified diabetes mellitus with diabetic dermatitis	Diagnosis	ICD-10-CM
E13.621	Other specified diabetes mellitus with foot ulcer	Diagnosis	ICD-10-CM
E13.622	Other specified diabetes mellitus with other skin ulcer	Diagnosis	ICD-10-CM
E13.628	Other specified diabetes mellitus with other skin complications	Diagnosis	ICD-10-CM
E13.630	Other specified diabetes mellitus with periodontal disease	Diagnosis	ICD-10-CM
E13.638	Other specified diabetes mellitus with other oral complications	Diagnosis	ICD-10-CM
E13.641	Other specified diabetes mellitus with hypoglycemia with coma	Diagnosis	ICD-10-CM
E13.649	Other specified diabetes mellitus with hypoglycemia without coma	Diagnosis	ICD-10-CM
E13.65	Other specified diabetes mellitus with hyperglycemia	Diagnosis	ICD-10-CM
E13.69	Other specified diabetes mellitus with other specified complication	Diagnosis	ICD-10-CM
E13.8	Other specified diabetes mellitus with unspecified complications	Diagnosis	ICD-10-CM
E13.9	Other specified diabetes mellitus without complications	Diagnosis	ICD-10-CM
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	Diagnosis	ICD-10-CM
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	Diagnosis	ICD-10-CM
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	Diagnosis	ICD-10-CM
E10.3529	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	Diagnosis	ICD-10-CM
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	Diagnosis	ICD-10-CM
E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	Diagnosis	ICD-10-CM
E10.3539	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	Diagnosis	ICD-10-CM
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	Diagnosis	ICD-10-CM
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	Diagnosis	ICD-10-CM
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	Diagnosis	ICD-10-CM
E10.3549	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	Diagnosis	ICD-10-CM
E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	Diagnosis	ICD-10-CM
E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	Diagnosis	ICD-10-CM
E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	Diagnosis	ICD-10-CM
E10.3559	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	Diagnosis	ICD-10-CM
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E10.3599	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
E13.3591	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	Diagnosis	ICD-10-CM
E13.3592	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	Diagnosis	ICD-10-CM
E13.3593	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	Diagnosis	ICD-10-CM
E13.3599	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	Diagnosis	ICD-10-CM
Heart failure or non-ischemic heart disease			
I09.81	Rheumatic heart failure	Diagnosis	ICD-10-CM
I11.0	Hypertensive heart disease with heart failure	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	Diagnosis	ICD-10-CM
I50.1	Left ventricular failure, unspecified	Diagnosis	ICD-10-CM
I50.20	Unspecified systolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.21	Acute systolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.22	Chronic systolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.23	Acute on chronic systolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.30	Unspecified diastolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.31	Acute diastolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.32	Chronic diastolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.33	Acute on chronic diastolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure	Diagnosis	ICD-10-CM
I50.810	Right heart failure, unspecified	Diagnosis	ICD-10-CM
I50.811	Acute right heart failure	Diagnosis	ICD-10-CM
I50.812	Chronic right heart failure	Diagnosis	ICD-10-CM
I50.813	Acute on chronic right heart failure	Diagnosis	ICD-10-CM
I50.814	Right heart failure due to left heart failure	Diagnosis	ICD-10-CM
I50.82	Biventricular heart failure	Diagnosis	ICD-10-CM
I50.83	High output heart failure	Diagnosis	ICD-10-CM
I50.84	End stage heart failure	Diagnosis	ICD-10-CM
I50.89	Other heart failure	Diagnosis	ICD-10-CM
I50.9	Heart failure, unspecified	Diagnosis	ICD-10-CM
I42.0	Dilated cardiomyopathy	Diagnosis	ICD-10-CM
I42.5	Other restrictive cardiomyopathy	Diagnosis	ICD-10-CM
I42.6	Alcoholic cardiomyopathy	Diagnosis	ICD-10-CM
I42.7	Cardiomyopathy due to drug and external agent	Diagnosis	ICD-10-CM
I42.8	Other cardiomyopathies	Diagnosis	ICD-10-CM
I43	Cardiomyopathy in diseases classified elsewhere	Diagnosis	ICD-10-CM
P29.0	Neonatal cardiac failure	Diagnosis	ICD-10-CM
	Hyperlipidemia		
K83.01	Primary sclerosing cholangitis	Diagnosis	ICD-10-CM
E78.0	Pure hypercholesterolemia	Diagnosis	ICD-10-CM
E78.1	Pure hyperglyceridemia	Diagnosis	ICD-10-CM
E78.2	Mixed hyperlipidemia	Diagnosis	ICD-10-CM
E78.3	Hyperchylomicronemia	Diagnosis	ICD-10-CM
E78.4	Other hyperlipidemia	Diagnosis	ICD-10-CM
E78.5	Hyperlipidemia, unspecified	Diagnosis	ICD-10-CM
E78.00	Pure hypercholesterolemia, unspecified	Diagnosis	ICD-10-CM
E78.01	Familial hypercholesterolemia	Diagnosis	ICD-10-CM
E78.41	Elevated Lipoprotein(a)	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
E78.49	Other hyperlipidemia	Diagnosis	ICD-10-CM
	Hypertension		
H35.031	Hypertensive retinopathy, right eye	Diagnosis	ICD-10-CM
H35.032	Hypertensive retinopathy, left eye	Diagnosis	ICD-10-CM
H35.033	Hypertensive retinopathy, bilateral	Diagnosis	ICD-10-CM
H35.039	Hypertensive retinopathy, unspecified eye	Diagnosis	ICD-10-CM
I10	Essential (primary) hypertension	Diagnosis	ICD-10-CM
I11.0	Hypertensive heart disease with heart failure	Diagnosis	ICD-10-CM
I11.9	Hypertensive heart disease without heart failure	Diagnosis	ICD-10-CM
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	Diagnosis	ICD-10-CM
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease	Diagnosis	ICD-10-CM
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	Diagnosis	ICD-10-CM
I15.0	Renovascular hypertension	Diagnosis	ICD-10-CM
I15.1	Hypertension secondary to other renal disorders	Diagnosis	ICD-10-CM
I15.2	Hypertension secondary to endocrine disorders	Diagnosis	ICD-10-CM
I15.8	Other secondary hypertension	Diagnosis	ICD-10-CM
I15.9	Secondary hypertension, unspecified	Diagnosis	ICD-10-CM
I67.4	Hypertensive encephalopathy	Diagnosis	ICD-10-CM
N26.2	Page kidney	Diagnosis	ICD-10-CM
	Ischemic heart disease		
I20.0	Unstable angina	Diagnosis	ICD-10-CM
I20.1	Angina pectoris with documented spasm	Diagnosis	ICD-10-CM
I20.8	Other forms of angina pectoris	Diagnosis	ICD-10-CM
I20.9	Angina pectoris, unspecified	Diagnosis	ICD-10-CM
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery	Diagnosis	ICD-10-CM
I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery	Diagnosis	ICD-10-CM
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall	Diagnosis	ICD-10-CM
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery	Diagnosis	ICD-10-CM
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall	Diagnosis	ICD-10-CM
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery	Diagnosis	ICD-10-CM
I21.29	ST elevation (STEMI) myocardial infarction involving other sites	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site	Diagnosis	ICD-10-CM
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	Diagnosis	ICD-10-CM
I21.A1	Myocardial infarction type 2	Diagnosis	ICD-10-CM
I21.A9	Other myocardial infarction type	Diagnosis	ICD-10-CM
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall	Diagnosis	ICD-10-CM
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall	Diagnosis	ICD-10-CM
I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction	Diagnosis	ICD-10-CM
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites	Diagnosis	ICD-10-CM
I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site	Diagnosis	ICD-10-CM
I23.0	Hemopericardium as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.1	Atrial septal defect as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.2	Ventricular septal defect as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.3	Rupture of cardiac wall without hemopericardium as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.4	Rupture of chordae tendineae as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.5	Rupture of papillary muscle as current complication following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.6	Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction	Diagnosis	ICD-10-CM
I23.7	Postinfarction angina	Diagnosis	ICD-10-CM
I23.8	Other current complications following acute myocardial infarction	Diagnosis	ICD-10-CM
I24.0	Acute coronary thrombosis not resulting in myocardial infarction	Diagnosis	ICD-10-CM
I24.1	Dressler's syndrome	Diagnosis	ICD-10-CM
I24.8	Other forms of acute ischemic heart disease	Diagnosis	ICD-10-CM
I24.9	Acute ischemic heart disease, unspecified	Diagnosis	ICD-10-CM
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris	Diagnosis	ICD-10-CM
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris	Diagnosis	ICD-10-CM
I25.111	Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm	Diagnosis	ICD-10-CM
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris	Diagnosis	ICD-10-CM
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	Diagnosis	ICD-10-CM
I25.2	Old myocardial infarction	Diagnosis	ICD-10-CM
I25.3	Aneurysm of heart	Diagnosis	ICD-10-CM
I25.41	Coronary artery aneurysm	Diagnosis	ICD-10-CM
I25.42	Coronary artery dissection	Diagnosis	ICD-10-CM
I25.5	Ischemic cardiomyopathy	Diagnosis	ICD-10-CM
I25.6	Silent myocardial ischemia	Diagnosis	ICD-10-CM
I25.700	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
I25.701	Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm	Diagnosis	ICD-10-CM
I25.708	Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris	Diagnosis	ICD-10-CM
I25.709	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris	Diagnosis	ICD-10-CM
I25.710	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris	Diagnosis	ICD-10-CM
I25.711	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm	Diagnosis	ICD-10-CM
I25.718	Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris	Diagnosis	ICD-10-CM
I25.719	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris	Diagnosis	ICD-10-CM
I25.720	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris	Diagnosis	ICD-10-CM
I25.721	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm	Diagnosis	ICD-10-CM
I25.728	Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris	Diagnosis	ICD-10-CM
I25.729	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris	Diagnosis	ICD-10-CM
I25.730	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris	Diagnosis	ICD-10-CM
I25.731	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm	Diagnosis	ICD-10-CM
I25.738	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris	Diagnosis	ICD-10-CM
I25.739	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris	Diagnosis	ICD-10-CM
I25.750	Atherosclerosis of native coronary artery of transplanted heart with unstable angina	Diagnosis	ICD-10-CM
I25.751	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm	Diagnosis	ICD-10-CM
I25.758	Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris	Diagnosis	ICD-10-CM
I25.759	Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris	Diagnosis	ICD-10-CM
I25.760	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina	Diagnosis	ICD-10-CM
I25.761	Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm	Diagnosis	ICD-10-CM
I25.768	Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris	Diagnosis	ICD-10-CM
I25.769	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
I25.790	Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris	Diagnosis	ICD-10-CM
I25.791	Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm	Diagnosis	ICD-10-CM
I25.798	Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris	Diagnosis	ICD-10-CM
I25.799	Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris	Diagnosis	ICD-10-CM
I25.810	Atherosclerosis of coronary artery bypass graft(s) without angina pectoris	Diagnosis	ICD-10-CM
I25.811	Atherosclerosis of native coronary artery of transplanted heart without angina pectoris	Diagnosis	ICD-10-CM
I25.812	Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris	Diagnosis	ICD-10-CM
I25.82	Chronic total occlusion of coronary artery	Diagnosis	ICD-10-CM
I25.83	Coronary atherosclerosis due to lipid rich plaque	Diagnosis	ICD-10-CM
I25.84	Coronary atherosclerosis due to calcified coronary lesion	Diagnosis	ICD-10-CM
I25.89	Other forms of chronic ischemic heart disease	Diagnosis	ICD-10-CM
I25.9	Chronic ischemic heart disease, unspecified	Diagnosis	ICD-10-CM
	Non-Alzheimer's dementia		
F01.50	Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	Diagnosis	ICD-10-CM
F01.51	Vascular dementia, unspecified severity, with behavioral disturbance	Diagnosis	ICD-10-CM
F02.80	Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	Diagnosis	ICD-10-CM
F02.81	Dementia in other diseases classified elsewhere, unspecified severity, with behavioral disturbance	Diagnosis	ICD-10-CM
F03.90	Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety	Diagnosis	ICD-10-CM
F03.91	Unspecified dementia, unspecified severity, with behavioral disturbance	Diagnosis	ICD-10-CM
F05	Delirium due to known physiological condition	Diagnosis	ICD-10-CM
G13.8	Systemic atrophy primarily affecting central nervous system in other diseases classified elsewhere	Diagnosis	ICD-10-CM
G31.01	Pick's disease	Diagnosis	ICD-10-CM
G31.09	Other frontotemporal neurocognitive disorder	Diagnosis	ICD-10-CM
G31.1	Senile degeneration of brain, not elsewhere classified	Diagnosis	ICD-10-CM
G31.2	Degeneration of nervous system due to alcohol	Diagnosis	ICD-10-CM
G31.83	Neurocognitive disorder with Lewy bodies	Diagnosis	ICD-10-CM
G94	Other disorders of brain in diseases classified elsewhere	Diagnosis	ICD-10-CM
R41.81	Age-related cognitive decline	Diagnosis	ICD-10-CM
	Parkinson'sdisease or secondary parkinsonism		
G20	Parkinson's disease	Diagnosis	ICD-10-CM
G20.A	Parkinson's disease without dyskinesia	Diagnosis	ICD-10-CM
G20.A1	Parkinson's disease without dyskinesia, without mention of fluctuations	Diagnosis	ICD-10-CM
G20.A2	Parkinson's disease without dyskinesia, with fluctuations	Diagnosis	ICD-10-CM
G20.B	Parkinson's disease with dyskinesia	Diagnosis	ICD-10-CM
G20.B1	Parkinson's disease with dyskinesia, without mention of fluctuations	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
G20.B2	Parkinson's disease with dyskinesia, with fluctuations	Diagnosis	ICD-10-CM
G20.C	parkinsonism, unspecified	Diagnosis	ICD-10-CM
G21	Secondary parkinsonism	Diagnosis	ICD-10-CM
G21.1	Other drug-induced secondary parkinsonism	Diagnosis	ICD-10-CM
G21.11	Neuroleptic induced parkinsonism	Diagnosis	ICD-10-CM
G21.19	Other drug induced secondary parkinsonism	Diagnosis	ICD-10-CM
G21.3	Postencephalitic parkinsonism	Diagnosis	ICD-10-CM
G21.4	Vascular parkinsonism	Diagnosis	ICD-10-CM
G21.8	Other secondary parkinsonism	Diagnosis	ICD-10-CM
G21.9	Secondary parkinsonism, unspecified	Diagnosis	ICD-10-CM
G31.83	Neurocognitive disorder with Lewy bodies	Diagnosis	ICD-10-CM
Pneumonia (all cause)			
A01.03	Typhoid pneumonia	Diagnosis	ICD-10-CM
A02.22	Salmonella pneumonia	Diagnosis	ICD-10-CM
A06.5	Amebic lung abscess	Diagnosis	ICD-10-CM
A20.2	Pneumonic plague	Diagnosis	ICD-10-CM
A21.2	Pulmonary tularemia	Diagnosis	ICD-10-CM
A22.1	Pulmonary anthrax	Diagnosis	ICD-10-CM
A31.0	Pulmonary mycobacterial infection	Diagnosis	ICD-10-CM
A37.01	Whooping cough due to Bordetella pertussis with pneumonia	Diagnosis	ICD-10-CM
A37.11	Whooping cough due to Bordetella parapertussis with pneumonia	Diagnosis	ICD-10-CM
A37.81	Whooping cough due to other Bordetella species with pneumonia	Diagnosis	ICD-10-CM
A37.91	Whooping cough, unspecified species with pneumonia	Diagnosis	ICD-10-CM
A40.3	Sepsis due to Streptococcus pneumoniae	Diagnosis	ICD-10-CM
A42.0	Pulmonary actinomycosis	Diagnosis	ICD-10-CM
A43.0	Pulmonary nocardiosis	Diagnosis	ICD-10-CM
A48.1	Legionnaires' disease	Diagnosis	ICD-10-CM
A50.04	Early congenital syphilitic pneumonia	Diagnosis	ICD-10-CM
A54.84	Gonococcal pneumonia	Diagnosis	ICD-10-CM
B01.2	Varicella pneumonia	Diagnosis	ICD-10-CM
B05.2	Measles complicated by pneumonia	Diagnosis	ICD-10-CM
B06.81	Rubella pneumonia	Diagnosis	ICD-10-CM
B37.1	Pulmonary candidiasis	Diagnosis	ICD-10-CM
B38.0	Acute pulmonary coccidioidomycosis	Diagnosis	ICD-10-CM
B38.2	Pulmonary coccidioidomycosis, unspecified	Diagnosis	ICD-10-CM
B39.0	Acute pulmonary histoplasmosis capsulati	Diagnosis	ICD-10-CM
B39.2	Pulmonary histoplasmosis capsulati, unspecified	Diagnosis	ICD-10-CM
B40.0	Acute pulmonary blastomycosis	Diagnosis	ICD-10-CM
B40.2	Pulmonary blastomycosis, unspecified	Diagnosis	ICD-10-CM
B41.0	Pulmonary paracoccidioidomycosis	Diagnosis	ICD-10-CM
B58.3	Pulmonary toxoplasmosis	Diagnosis	ICD-10-CM
B59	Pneumocystosis	Diagnosis	ICD-10-CM
B66.4	Paragonimiasis	Diagnosis	ICD-10-CM
B67.1	Echinococcus granulosus infection of lung	Diagnosis	ICD-10-CM
B77.81	Ascariasis pneumonia	Diagnosis	ICD-10-CM
B95.3	Streptococcus pneumoniae as the cause of diseases classified elsewhere	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
B96.0	Mycoplasma pneumoniae [M. pneumoniae] as the cause of diseases classified elsewhere	Diagnosis	ICD-10-CM
B96.1	Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified elsewhere	Diagnosis	ICD-10-CM
J09.X1	Influenza due to identified novel influenza A virus with pneumonia	Diagnosis	ICD-10-CM
J10.00	Influenza due to other identified influenza virus with unspecified type of pneumonia	Diagnosis	ICD-10-CM
J10.01	Influenza due to other identified influenza virus with the same other identified influenza virus pneumonia	Diagnosis	ICD-10-CM
J10.08	Influenza due to other identified influenza virus with other specified pneumonia	Diagnosis	ICD-10-CM
J11.00	Influenza due to unidentified influenza virus with unspecified type of pneumonia	Diagnosis	ICD-10-CM
J11.08	Influenza due to unidentified influenza virus with specified pneumonia	Diagnosis	ICD-10-CM
J12.0	Adenoviral pneumonia	Diagnosis	ICD-10-CM
J12.1	Respiratory syncytial virus pneumonia	Diagnosis	ICD-10-CM
J12.2	Parainfluenza virus pneumonia	Diagnosis	ICD-10-CM
J12.3	Human metapneumovirus pneumonia	Diagnosis	ICD-10-CM
J12.81	Pneumonia due to SARS-associated coronavirus	Diagnosis	ICD-10-CM
J12.82	Pneumonia due to coronavirus disease 2019	Diagnosis	ICD-10-CM
J12.89	Other viral pneumonia	Diagnosis	ICD-10-CM
J12.9	Viral pneumonia, unspecified	Diagnosis	ICD-10-CM
J13	Pneumonia due to Streptococcus pneumoniae	Diagnosis	ICD-10-CM
J14	Pneumonia due to Hemophilus influenzae	Diagnosis	ICD-10-CM
J15.0	Pneumonia due to Klebsiella pneumoniae	Diagnosis	ICD-10-CM
J15.1	Pneumonia due to Pseudomonas	Diagnosis	ICD-10-CM
J15.20	Pneumonia due to staphylococcus, unspecified	Diagnosis	ICD-10-CM
J15.211	Pneumonia due to Methicillin susceptible Staphylococcus aureus	Diagnosis	ICD-10-CM
J15.212	Pneumonia due to Methicillin resistant Staphylococcus aureus	Diagnosis	ICD-10-CM
J15.29	Pneumonia due to other staphylococcus	Diagnosis	ICD-10-CM
J15.3	Pneumonia due to streptococcus, group B	Diagnosis	ICD-10-CM
J15.4	Pneumonia due to other streptococci	Diagnosis	ICD-10-CM
J15.5	Pneumonia due to Escherichia coli	Diagnosis	ICD-10-CM
J15.6	Pneumonia due to other Gram-negative bacteria	Diagnosis	ICD-10-CM
J15.61	Pneumonia due to Acinetobacter baumannii	Diagnosis	ICD-10-CM
J15.69	Pneumonia due to other Gram-negative bacteria	Diagnosis	ICD-10-CM
J15.7	Pneumonia due to Mycoplasma pneumoniae	Diagnosis	ICD-10-CM
J15.8	Pneumonia due to other specified bacteria	Diagnosis	ICD-10-CM
J15.9	Unspecified bacterial pneumonia	Diagnosis	ICD-10-CM
J16.0	Chlamydial pneumonia	Diagnosis	ICD-10-CM
J16.8	Pneumonia due to other specified infectious organisms	Diagnosis	ICD-10-CM
J17	Pneumonia in diseases classified elsewhere	Diagnosis	ICD-10-CM
J18.0	Bronchopneumonia, unspecified organism	Diagnosis	ICD-10-CM
J18.1	Lobar pneumonia, unspecified organism	Diagnosis	ICD-10-CM
J18.2	Hypostatic pneumonia, unspecified organism	Diagnosis	ICD-10-CM
J18.8	Other pneumonia, unspecified organism	Diagnosis	ICD-10-CM
J18.9	Pneumonia, unspecified organism	Diagnosis	ICD-10-CM

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Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
J20.0	Acute bronchitis due to Mycoplasma pneumoniae	Diagnosis	ICD-10-CM
J84.111	Idiopathic interstitial pneumonia, not otherwise specified	Diagnosis	ICD-10-CM
J84.116	Cryptogenic organizing pneumonia	Diagnosis	ICD-10-CM
J84.117	Desquamative interstitial pneumonia	Diagnosis	ICD-10-CM
J84.178	Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere	Diagnosis	ICD-10-CM
J84.2	Lymphoid interstitial pneumonia	Diagnosis	ICD-10-CM
J85.1	Abscess of lung with pneumonia	Diagnosis	ICD-10-CM
J95.851	Ventilator associated pneumonia	Diagnosis	ICD-10-CM
P23.0	Congenital pneumonia due to viral agent	Diagnosis	ICD-10-CM
P23.1	Congenital pneumonia due to Chlamydia	Diagnosis	ICD-10-CM
P23.2	Congenital pneumonia due to staphylococcus	Diagnosis	ICD-10-CM
P23.3	Congenital pneumonia due to streptococcus, group B	Diagnosis	ICD-10-CM
P23.4	Congenital pneumonia due to Escherichia coli	Diagnosis	ICD-10-CM
P23.5	Congenital pneumonia due to Pseudomonas	Diagnosis	ICD-10-CM
P23.6	Congenital pneumonia due to other bacterial agents	Diagnosis	ICD-10-CM
P23.8	Congenital pneumonia due to other organisms	Diagnosis	ICD-10-CM
P23.9	Congenital pneumonia, unspecified	Diagnosis	ICD-10-CM
Z87.01	Personal history of pneumonia (recurrent)	Diagnosis	ICD-10-CM
	Stroke or transient ischemic attack		
G45.0	Vertebro-basilar artery syndrome	Diagnosis	ICD-10-CM
G45.1	Carotid artery syndrome (hemispheric)	Diagnosis	ICD-10-CM
G45.2	Multiple and bilateral precerebral artery syndromes	Diagnosis	ICD-10-CM
G45.3	Amaurosis fugax	Diagnosis	ICD-10-CM
G45.8	Other transient cerebral ischemic attacks and related syndromes	Diagnosis	ICD-10-CM
G45.9	Transient cerebral ischemic attack, unspecified	Diagnosis	ICD-10-CM
G46.0	Middle cerebral artery syndrome	Diagnosis	ICD-10-CM
G46.1	Anterior cerebral artery syndrome	Diagnosis	ICD-10-CM
G46.2	Posterior cerebral artery syndrome	Diagnosis	ICD-10-CM
G46.3	Brain stem stroke syndrome	Diagnosis	ICD-10-CM
G46.4	Cerebellar stroke syndrome	Diagnosis	ICD-10-CM
G46.5	Pure motor lacunar syndrome	Diagnosis	ICD-10-CM
G46.6	Pure sensory lacunar syndrome	Diagnosis	ICD-10-CM
G46.7	Other lacunar syndromes	Diagnosis	ICD-10-CM
G46.8	Other vascular syndromes of brain in cerebrovascular diseases	Diagnosis	ICD-10-CM
G97.31	Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating a nervous system procedure	Diagnosis	ICD-10-CM
G97.32	Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating other procedure	Diagnosis	ICD-10-CM
I60.00	Nontraumatic subarachnoid hemorrhage from unspecified carotid siphon and bifurcation	Diagnosis	ICD-10-CM
I60.01	Nontraumatic subarachnoid hemorrhage from right carotid siphon and bifurcation	Diagnosis	ICD-10-CM
I60.02	Nontraumatic subarachnoid hemorrhage from left carotid siphon and bifurcation	Diagnosis	ICD-10-CM
I60.10	Nontraumatic subarachnoid hemorrhage from unspecified middle cerebral artery	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
I60.11	Nontraumatic subarachnoid hemorrhage from right middle cerebral artery	Diagnosis	ICD-10-CM
I60.12	Nontraumatic subarachnoid hemorrhage from left middle cerebral artery	Diagnosis	ICD-10-CM
I60.2	Nontraumatic subarachnoid hemorrhage from anterior communicating artery	Diagnosis	ICD-10-CM
I60.20	Nontraumatic subarachnoid hemorrhage from unspecified anterior communicating artery	Diagnosis	ICD-10-CM
I60.21	Nontraumatic subarachnoid hemorrhage from right anterior communicating artery	Diagnosis	ICD-10-CM
I60.22	Nontraumatic subarachnoid hemorrhage from left anterior communicating artery	Diagnosis	ICD-10-CM
I60.30	Nontraumatic subarachnoid hemorrhage from unspecified posterior communicating artery	Diagnosis	ICD-10-CM
I60.31	Nontraumatic subarachnoid hemorrhage from right posterior communicating artery	Diagnosis	ICD-10-CM
I60.32	Nontraumatic subarachnoid hemorrhage from left posterior communicating artery	Diagnosis	ICD-10-CM
I60.4	Nontraumatic subarachnoid hemorrhage from basilar artery	Diagnosis	ICD-10-CM
I60.50	Nontraumatic subarachnoid hemorrhage from unspecified vertebral artery	Diagnosis	ICD-10-CM
I60.51	Nontraumatic subarachnoid hemorrhage from right vertebral artery	Diagnosis	ICD-10-CM
I60.52	Nontraumatic subarachnoid hemorrhage from left vertebral artery	Diagnosis	ICD-10-CM
I60.6	Nontraumatic subarachnoid hemorrhage from other intracranial arteries	Diagnosis	ICD-10-CM
I60.7	Nontraumatic subarachnoid hemorrhage from unspecified intracranial artery	Diagnosis	ICD-10-CM
I60.8	Other nontraumatic subarachnoid hemorrhage	Diagnosis	ICD-10-CM
I60.9	Nontraumatic subarachnoid hemorrhage, unspecified	Diagnosis	ICD-10-CM
I61.0	Nontraumatic intracerebral hemorrhage in hemisphere, subcortical	Diagnosis	ICD-10-CM
I61.1	Nontraumatic intracerebral hemorrhage in hemisphere, cortical	Diagnosis	ICD-10-CM
I61.2	Nontraumatic intracerebral hemorrhage in hemisphere, unspecified	Diagnosis	ICD-10-CM
I61.3	Nontraumatic intracerebral hemorrhage in brain stem	Diagnosis	ICD-10-CM
I61.4	Nontraumatic intracerebral hemorrhage in cerebellum	Diagnosis	ICD-10-CM
I61.5	Nontraumatic intracerebral hemorrhage, intraventricular	Diagnosis	ICD-10-CM
I61.6	Nontraumatic intracerebral hemorrhage, multiple localized	Diagnosis	ICD-10-CM
I61.8	Other nontraumatic intracerebral hemorrhage	Diagnosis	ICD-10-CM
I61.9	Nontraumatic intracerebral hemorrhage, unspecified	Diagnosis	ICD-10-CM
I62.00	Nontraumatic subdural hemorrhage, unspecified	Diagnosis	ICD-10-CM
I62.01	Nontraumatic acute subdural hemorrhage	Diagnosis	ICD-10-CM
I62.02	Nontraumatic subacute subdural hemorrhage	Diagnosis	ICD-10-CM
I62.9	Nontraumatic intracranial hemorrhage, unspecified	Diagnosis	ICD-10-CM
I63.00	Cerebral infarction due to thrombosis of unspecified precerebral artery	Diagnosis	ICD-10-CM
I63.011	Cerebral infarction due to thrombosis of right vertebral artery	Diagnosis	ICD-10-CM
I63.012	Cerebral infarction due to thrombosis of left vertebral artery	Diagnosis	ICD-10-CM
I63.013	Cerebral infarction due to thrombosis of bilateral vertebral arteries	Diagnosis	ICD-10-CM
I63.019	Cerebral infarction due to thrombosis of unspecified vertebral artery	Diagnosis	ICD-10-CM
I63.02	Cerebral infarction due to thrombosis of basilar artery	Diagnosis	ICD-10-CM
I63.031	Cerebral infarction due to thrombosis of right carotid artery	Diagnosis	ICD-10-CM
I63.032	Cerebral infarction due to thrombosis of left carotid artery	Diagnosis	ICD-10-CM
I63.033	Cerebral infarction due to thrombosis of bilateral carotid arteries	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
I63.039	Cerebral infarction due to thrombosis of unspecified carotid artery	Diagnosis	ICD-10-CM
I63.09	Cerebral infarction due to thrombosis of other precerebral artery	Diagnosis	ICD-10-CM
I63.10	Cerebral infarction due to embolism of unspecified precerebral artery	Diagnosis	ICD-10-CM
I63.111	Cerebral infarction due to embolism of right vertebral artery	Diagnosis	ICD-10-CM
I63.112	Cerebral infarction due to embolism of left vertebral artery	Diagnosis	ICD-10-CM
I63.113	Cerebral infarction due to embolism of bilateral vertebral arteries	Diagnosis	ICD-10-CM
I63.119	Cerebral infarction due to embolism of unspecified vertebral artery	Diagnosis	ICD-10-CM
I63.12	Cerebral infarction due to embolism of basilar artery	Diagnosis	ICD-10-CM
I63.131	Cerebral infarction due to embolism of right carotid artery	Diagnosis	ICD-10-CM
I63.132	Cerebral infarction due to embolism of left carotid artery	Diagnosis	ICD-10-CM
I63.133	Cerebral infarction due to embolism of bilateral carotid arteries	Diagnosis	ICD-10-CM
I63.139	Cerebral infarction due to embolism of unspecified carotid artery	Diagnosis	ICD-10-CM
I63.19	Cerebral infarction due to embolism of other precerebral artery	Diagnosis	ICD-10-CM
I63.20	Cerebral infarction due to unspecified occlusion or stenosis of unspecified precerebral arteries	Diagnosis	ICD-10-CM
I63.211	Cerebral infarction due to unspecified occlusion or stenosis of right vertebral artery	Diagnosis	ICD-10-CM
I63.212	Cerebral infarction due to unspecified occlusion or stenosis of left vertebral artery	Diagnosis	ICD-10-CM
I63.213	Cerebral infarction due to unspecified occlusion or stenosis of bilateral vertebral arteries	Diagnosis	ICD-10-CM
I63.219	Cerebral infarction due to unspecified occlusion or stenosis of unspecified vertebral artery	Diagnosis	ICD-10-CM
I63.22	Cerebral infarction due to unspecified occlusion or stenosis of basilar	Diagnosis	ICD-10-CM
I63.231	Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries	Diagnosis	ICD-10-CM
I63.232	Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries	Diagnosis	ICD-10-CM
I63.233	Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries	Diagnosis	ICD-10-CM
I63.239	Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid artery	Diagnosis	ICD-10-CM
I63.29	Cerebral infarction due to unspecified occlusion or stenosis of other precerebral arteries	Diagnosis	ICD-10-CM
I63.30	Cerebral infarction due to thrombosis of unspecified cerebral artery	Diagnosis	ICD-10-CM
I63.311	Cerebral infarction due to thrombosis of right middle cerebral artery	Diagnosis	ICD-10-CM
I63.312	Cerebral infarction due to thrombosis of left middle cerebral artery	Diagnosis	ICD-10-CM
I63.313	Cerebral infarction due to thrombosis of bilateral middle cerebral arteries	Diagnosis	ICD-10-CM
I63.319	Cerebral infarction due to thrombosis of unspecified middle cerebral	Diagnosis	ICD-10-CM
I63.321	Cerebral infarction due to thrombosis of right anterior cerebral artery	Diagnosis	ICD-10-CM
I63.322	Cerebral infarction due to thrombosis of left anterior cerebral artery	Diagnosis	ICD-10-CM
I63.323	Cerebral infarction due to thrombosis of bilateral anterior cerebral arteries	Diagnosis	ICD-10-CM
I63.329	Cerebral infarction due to thrombosis of unspecified anterior cerebral artery	Diagnosis	ICD-10-CM
I63.331	Cerebral infarction due to thrombosis of right posterior cerebral artery	Diagnosis	ICD-10-CM
I63.332	Cerebral infarction due to thrombosis of left posterior cerebral artery	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
I63.333	Cerebral infarction due to thrombosis of bilateral posterior cerebral arteries	Diagnosis	ICD-10-CM
I63.339	Cerebral infarction due to thrombosis of unspecified posterior cerebral artery	Diagnosis	ICD-10-CM
I63.341	Cerebral infarction due to thrombosis of right cerebellar artery	Diagnosis	ICD-10-CM
I63.342	Cerebral infarction due to thrombosis of left cerebellar artery	Diagnosis	ICD-10-CM
I63.343	Cerebral infarction due to thrombosis of bilateral cerebellar arteries	Diagnosis	ICD-10-CM
I63.349	Cerebral infarction due to thrombosis of unspecified cerebellar artery	Diagnosis	ICD-10-CM
I63.39	Cerebral infarction due to thrombosis of other cerebral artery	Diagnosis	ICD-10-CM
I63.40	Cerebral infarction due to embolism of unspecified cerebral artery	Diagnosis	ICD-10-CM
I63.411	Cerebral infarction due to embolism of right middle cerebral artery	Diagnosis	ICD-10-CM
I63.412	Cerebral infarction due to embolism of left middle cerebral artery	Diagnosis	ICD-10-CM
I63.413	Cerebral infarction due to embolism of bilateral middle cerebral arteries	Diagnosis	ICD-10-CM
I63.419	Cerebral infarction due to embolism of unspecified middle cerebral artery	Diagnosis	ICD-10-CM
I63.421	Cerebral infarction due to embolism of right anterior cerebral artery	Diagnosis	ICD-10-CM
I63.422	Cerebral infarction due to embolism of left anterior cerebral artery	Diagnosis	ICD-10-CM
I63.423	Cerebral infarction due to embolism of bilateral anterior cerebral arteries	Diagnosis	ICD-10-CM
I63.429	Cerebral infarction due to embolism of unspecified anterior cerebral artery	Diagnosis	ICD-10-CM
I63.431	Cerebral infarction due to embolism of right posterior cerebral artery	Diagnosis	ICD-10-CM
I63.432	Cerebral infarction due to embolism of left posterior cerebral artery	Diagnosis	ICD-10-CM
I63.433	Cerebral infarction due to embolism of bilateral posterior cerebral arteries	Diagnosis	ICD-10-CM
I63.439	Cerebral infarction due to embolism of unspecified posterior cerebral artery	Diagnosis	ICD-10-CM
I63.441	Cerebral infarction due to embolism of right cerebellar artery	Diagnosis	ICD-10-CM
I63.442	Cerebral infarction due to embolism of left cerebellar artery	Diagnosis	ICD-10-CM
I63.443	Cerebral infarction due to embolism of bilateral cerebellar arteries	Diagnosis	ICD-10-CM
I63.449	Cerebral infarction due to embolism of unspecified cerebellar artery	Diagnosis	ICD-10-CM
I63.49	Cerebral infarction due to embolism of other cerebral artery	Diagnosis	ICD-10-CM
I63.50	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery	Diagnosis	ICD-10-CM
I63.511	Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery	Diagnosis	ICD-10-CM
I63.512	Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery	Diagnosis	ICD-10-CM
I63.513	Cerebral infarction due to unspecified occlusion or stenosis of bilateral middle cerebral arteries	Diagnosis	ICD-10-CM
I63.519	Cerebral infarction due to unspecified occlusion or stenosis of unspecified middle cerebral artery	Diagnosis	ICD-10-CM
I63.521	Cerebral infarction due to unspecified occlusion or stenosis of right anterior cerebral artery	Diagnosis	ICD-10-CM
I63.522	Cerebral infarction due to unspecified occlusion or stenosis of left anterior cerebral artery	Diagnosis	ICD-10-CM
I63.523	Cerebral infarction due to unspecified occlusion or stenosis of bilateral anterior cerebral arteries	Diagnosis	ICD-10-CM
I63.529	Cerebral infarction due to unspecified occlusion or stenosis of unspecified anterior cerebral artery	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
I63.531	Cerebral infarction due to unspecified occlusion or stenosis of right posterior cerebral artery	Diagnosis	ICD-10-CM
I63.532	Cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery	Diagnosis	ICD-10-CM
I63.533	Cerebral infarction due to unspecified occlusion or stenosis of bilateral posterior cerebral arteries	Diagnosis	ICD-10-CM
I63.539	Cerebral infarction due to unspecified occlusion or stenosis of unspecified posterior cerebral artery	Diagnosis	ICD-10-CM
I63.541	Cerebral infarction due to unspecified occlusion or stenosis of right cerebellar artery	Diagnosis	ICD-10-CM
I63.542	Cerebral infarction due to unspecified occlusion or stenosis of left cerebellar artery	Diagnosis	ICD-10-CM
I63.543	Cerebral infarction due to unspecified occlusion or stenosis of bilateral cerebellar arteries	Diagnosis	ICD-10-CM
I63.549	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery	Diagnosis	ICD-10-CM
I63.59	Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery	Diagnosis	ICD-10-CM
I63.6	Cerebral infarction due to cerebral venous thrombosis, nonpyogenic	Diagnosis	ICD-10-CM
I63.8	Other cerebral infarction	Diagnosis	ICD-10-CM
I63.81	Other cerebral infarction due to occlusion or stenosis of small artery	Diagnosis	ICD-10-CM
I63.89	Other cerebral infarction	Diagnosis	ICD-10-CM
I63.9	Cerebral infarction, unspecified	Diagnosis	ICD-10-CM
I67.841	Reversible cerebrovascular vasoconstriction syndrome	Diagnosis	ICD-10-CM
I67.848	Other cerebrovascular vasospasm and vasoconstriction	Diagnosis	ICD-10-CM
I67.89	Other cerebrovascular disease	Diagnosis	ICD-10-CM
I97.810	Intraoperative cerebrovascular infarction during cardiac surgery	Diagnosis	ICD-10-CM
I97.811	Intraoperative cerebrovascular infarction during other surgery	Diagnosis	ICD-10-CM
I97.820	Postprocedural cerebrovascular infarction following cardiac surgery	Diagnosis	ICD-10-CM
I97.821	Postprocedural cerebrovascular infarction following other surgery	Diagnosis	ICD-10-CM
S06.340A	Traumatic hemorrhage of right cerebrum without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.341A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
S06.342A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.343A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.344A	Traumatic hemorrhage of right cerebrum with loss of consciousness of 6 hours to 24 hours, initial encounter	Diagnosis	ICD-10-CM
S06.345A	Traumatic hemorrhage of right cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.349A	Traumatic hemorrhage of right cerebrum with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.350A	Traumatic hemorrhage of left cerebrum without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.351A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
S06.352A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.353A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.354A	Traumatic hemorrhage of left cerebrum with loss of consciousness of 6 hours to 24 hours, initial encounter	Diagnosis	ICD-10-CM
S06.355A	Traumatic hemorrhage of left cerebrum with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.359A	Traumatic hemorrhage of left cerebrum with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.360A	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.361A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
S06.362A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 31 minutes to 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.363A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.364A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of 6 hours to 24 hours, initial encounter	Diagnosis	ICD-10-CM
S06.365A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.369A	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.370A	Contusion, laceration, and hemorrhage of cerebellum without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.371A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
S06.372A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 31 minutes to 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.373A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.374A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of 6 hours to 24 hours, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.379A	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.380A	Contusion, laceration, and hemorrhage of brainstem without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.381A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
S06.382A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 31 minutes to 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.383A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.384A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of 6 hours to 24 hours, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.389A	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.5X0A	Traumatic subdural hemorrhage without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.5X1A	Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
S06.5X2A	Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.5X3A	Traumatic subdural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.5X4A	Traumatic subdural hemorrhage with loss of consciousness of 6 hours to 24 hours, initial encounter	Diagnosis	ICD-10-CM
S06.5X5A	Traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.5X7A	Traumatic subdural hemorrhage with loss of consciousness of any duration with death due to brain injury before regaining consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.5X8A	Traumatic subdural hemorrhage with loss of consciousness of any duration with death due to other cause before regaining consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.5X9A	Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.6X0A	Traumatic subarachnoid hemorrhage without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.6X1A	Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
S06.6X2A	Traumatic subarachnoid hemorrhage with loss of consciousness of 31 minutes to 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.6X3A	Traumatic subarachnoid hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.6X4A	Traumatic subarachnoid hemorrhage with loss of consciousness of 6 hours to 24 hours, initial encounter	Diagnosis	ICD-10-CM
S06.6X5A	Traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
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	Diagnosis	ICD-10-CM
S06.6X7A	Traumatic subarachnoid hemorrhage with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.6X8A	Traumatic subarachnoid hemorrhage with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.6X9A	Traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.810A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.811A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.819A	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.820A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.821A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.829A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.890A	Other specified intracranial injury without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.891A	Other specified intracranial injury with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
S06.892A	Other specified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.893A	Other specified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.894A	Other specified intracranial injury with loss of consciousness of 6 hours to 24 hours, initial encounter	Diagnosis	ICD-10-CM
S06.895A	Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.899A	Other specified intracranial injury with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.9X0A	Unspecified intracranial injury without loss of consciousness, initial encounter	Diagnosis	ICD-10-CM

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes Used to Define Characteristics in this Request

Code	Description	Code Category	Code Type
S06.9X1A	Unspecified intracranial injury with loss of consciousness of 30 minutes or less, initial encounter	Diagnosis	ICD-10-CM
S06.9X2A	Unspecified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.9X3A	Unspecified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	Diagnosis	ICD-10-CM
S06.9X4A	Unspecified intracranial injury with loss of consciousness of 6 hours to 24 hours, initial encounter	Diagnosis	ICD-10-CM
S06.9X5A	Unspecified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	Diagnosis	ICD-10-CM
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	Diagnosis	ICD-10-CM
S06.9X7A	Unspecified intracranial injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.9X8A	Unspecified intracranial injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter	Diagnosis	ICD-10-CM
S06.9X9A	Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter	Diagnosis	ICD-10-CM
S06.A0XA	Traumatic brain compression without herniation, initial encounter	Diagnosis	ICD-10-CM
S06.A1XA	Traumatic brain compression with herniation, initial encounter	Diagnosis	ICD-10-CM
S06.34AA	Traumatic hemorrhage of right cerebrum with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.35AA	Traumatic hemorrhage of left cerebrum with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.36AA	Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.37AA	Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.38AA	Contusion, laceration, and hemorrhage of brainstem with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.5XAA	Traumatic subdural hemorrhage with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.6XAA	Traumatic subarachnoid hemorrhage with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.81AA	Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.82AA	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.89AA	Other specified intracranial injury with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM
S06.9XAA	Unspecified intracranial injury with loss of consciousness status unknown, initial encounter	Diagnosis	ICD-10-CM

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

Generic Name	Brand Name
Amoxapine	
amoxapine	Amoxapine
Isoniazid	
isoniazid	Isoniazid
rifampin/isoniazid	Rifamate
rifampin/isoniazid/pyrazinamide	Rifater
Atogepant	
atogepant	Qulipta
Inclisiran	
inclisiran sodium	Leqvio
Finerenone	
finerenone	Kerendia

Appendix E. Specifications Defining Parameters in this Request (r03)

This request executed the Cohort Identification and Descriptive Analysis (CIDA) tool [version 14.2.1] to characterize the Prescribing and Dispensing tables in the Sentinel Common Data Model by estimating rates of prescriptions and dispensings of amoxapine, isoniazid, atogepant, inclisiran, and finerenone in the Sentinel Distributed Database (SDD).

Query period: January 1, 2016 - May 31, 2025
Coverage requirement: Medical & Drug Coverage
Pre-index enrollment requirement: 365 days
Post-index requirement: None
Post-episode requirement for Type 2 analyses: None
Enrollment gap: 45 days
Age groups: 0-17, 18-24, 25-40, 41-64, 65+ years
Sex: M, F
Other Demographic Restrictions: Race, Hispanic Ethnicity
Stratifications: Age group, Sex
Censor output categorization: N/A (Dummy outcome)
Envelope macro: Reclassify encounters during inpatient stay as inpatient
Freeze data: No

	Exposure				
Scenario	**Index Exposure**	**Cohort Definition**	**Incident Exposure Washout Period**	**Exclude Evidence of Days Supply if Event Washout Includes Dispensings**	**Build Episodes on Point Exposure?**
1	Amoxapine Dispensing from the dispensing table	**01:** Cohort includes only the first valid exposure episode during the query period	N/A	N/A, no washout	**N:** Do not define exposure as a point exposure

Appendix E. Specifications Defining Parameters in this Request (r03)					
	Exposure				
Scenario	**Index Exposure**	**Cohort Definition**	**Incident Exposure Washout Period**	**Exclude Evidence of Days Supply if Event Washout Includes Dispensings**	**Build Episodes on Point Exposure?**
2	Isoniazid Dispensing from the dispensing table	**01:** Cohort includes only the first valid exposure episode during the query period	N/A	N/A, no washout	**N:** Do not define exposure as a point exposure
3	Atogepant Dispensing from the dispensing table	**01:** Cohort includes only the first valid exposure episode during the query period	N/A	N/A, no washout	**N:** Do not define exposure as a point exposure
4	Inclisiran Dispensing from the dispensing table	**01:** Cohort includes only the first valid exposure episode during the query period	N/A	N/A, no washout	**N:** Do not define exposure as a point exposure
5	Finerenone Dispensing from the dispensing table	**01:** Cohort includes only the first valid exposure episode during the query period	N/A	N/A, no washout	**N:** Do not define exposure as a point exposure

Sentinel

Appendix E. Specifications Defining Parameters in this Request (r03)									
	Exposure				Health Outcomes of Interest (HOI)				
Scenario	Minimum Exposure Episode Duration	Care Setting and Diagnosis Position Requirements	Create Baseline Table? (Y/N)	End At-Risk Period at Evidence of	Event	HOI Washout Period	Care Setting and Diagnosis Position Requirements	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Event De-Duplication
1	1	Any Care Setting	**Y**	Death Data Partner (DP) end date Query end date Occurrence of event	Dummy	None (N/A)	Any Care Setting	**N:** Lookback period should search for evidence of a date or an interval	**1:** de-duplicates occurrences of the same HOI code and code type on the same day (i.e., de-duplicates at the exact match code level).
2	1	Any Care Setting	**Y**	Death DP end date Query end date Occurrence of event	Dummy	None (N/A)	Any Care Setting	**N:** Lookback period should search for evidence of a date or an interval	**1:** de-duplicates occurrences of the same HOI code and code type on the same day (i.e., de-duplicates at the exact match code level).
3	1	Any Care Setting	**Y**	Death DP end date Query end date Occurrence of event	Dummy	None (N/A)	Any Care Setting	**N:** Lookback period should search for evidence of a date or an interval	**1:** de-duplicates occurrences of the same HOI code and code type on the same day (i.e., de-duplicates at the exact match code level).
4	1	Any Care Setting	**Y**	Death DP end date Query end date Occurrence of event	Dummy	None (N/A)	Any Care Setting	**N:** Lookback period should search for evidence of a date or an interval	**1:** de-duplicates occurrences of the same HOI code and code type on the same day (i.e., de-duplicates at the exact match code level).
5	1	Any Care Setting	**Y**	Death DP end date Query end date Occurrence of event	Dummy	None (N/A)	Any Care Setting	**N:** Lookback period should search for evidence of a date or an interval	**1:** de-duplicates occurrences of the same HOI code and code type on the same day (i.e., de-duplicates at the exact match code level).

International Classification of Diseases, Ninth Revision (ICD-9), International Classification of Diseases, Tenth Revision (ICD-10), Healthcare Common Procedure Coding System (HCPCS), and CPT (Current Procedural Terminology) codes are provided by Optum360. National Drug Codes (NDCs) are checked against FirstDataBank's FDBMedKnowledge®
N/A: Not applicable

Appendix F. Specifications Defining Baseline Characteristics for this Request (r03)

Baseline Characteristics

Covariate Name	Covariate Number	Code Category	Care Setting and Diagnosis Position Requirements	Covariate Evaluation Period Start	Covariate Evaluation Period End	Number of Instances the Covariate Should be Found in Evaluation Period	Lookback Period Date Only	Minimum Cumulative Number of Days *(only for CODECAT=RX)*
Evidence of Amoxapine Prescription before Dispensing	1	Prescribing	Any CareSetting	-30	0	1	N/A	1
	2	Prescribing	Any CareSetting	-60	-31	1	N/A	1
	3	Prescribing	Any CareSetting	-90	-61	1	N/A	1
	4	Prescribing	Any CareSetting	-183	-91	1	N/A	1
	5	Prescribing	Any CareSetting	-365	-184	1	N/A	1
Evidence of Isoniazid Prescription before Dispensing	6	Prescribing	Any CareSetting	-30	0	1	N/A	1
	7	Prescribing	Any CareSetting	-60	-31	1	N/A	1
	8	Prescribing	Any CareSetting	-90	-61	1	N/A	1
	9	Prescribing	Any CareSetting	-183	-91	1	N/A	1
	10	Prescribing	Any CareSetting	-365	-184	1	N/A	1
Evidence of Atogepant Prescription before Dispensing	11	Prescribing	Any CareSetting	-30	0	1	N/A	1
	12	Prescribing	Any CareSetting	-60	-31	1	N/A	1
	13	Prescribing	Any CareSetting	-90	-61	1	N/A	1
	14	Prescribing	Any CareSetting	-183	-91	1	N/A	1
	15	Prescribing	Any CareSetting	-365	-184	1	N/A	1

Appendix F. Specifications Defining Baseline Characteristics for this Request (r03)

Baseline Characteristics

Covariate Name	Covariate Number	Code Category	Care Setting and Diagnosis Position Requirements	Covariate Evaluation Period Start	Covariate Evaluation Period End	Number of Instances the Covariate Should be Found in Evaluation Period	Lookback Period Date Only	Minimum Cumulative Number of Days *(only for CODECAT=RX)*
Evidence of Inclisiran Prescription before Dispensing	16	Prescribing	Any CareSetting	-30	0	1	N/A	1
	17	Prescribing	Any CareSetting	-60	-31	1	N/A	1
	18	Prescribing	Any CareSetting	-90	-61	1	N/A	1
	19	Prescribing	Any CareSetting	-183	-91	1	N/A	1
	20	Prescribing	Any CareSetting	-365	-184	1	N/A	1
Evidence of Finerenone Prescription before Dispensing	21	Prescribing	Any CareSetting	-30	0	1	N/A	1
	22	Prescribing	Any CareSetting	-60	-31	1	N/A	1
	23	Prescribing	Any CareSetting	-90	-61	1	N/A	1
	24	Prescribing	Any CareSetting	-183	-91	1	N/A	1
	25	Prescribing	Any CareSetting	-365	-184	1	N/A	1
Chronic Conditions Warehouse								
Acute Myocardial Infarction	26	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Alzheimer's Disease	27	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Anemia	28	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Asthma	29	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	

Appendix F. Specifications Defining Baseline Characteristics for this Request (r03)

Baseline Characteristics

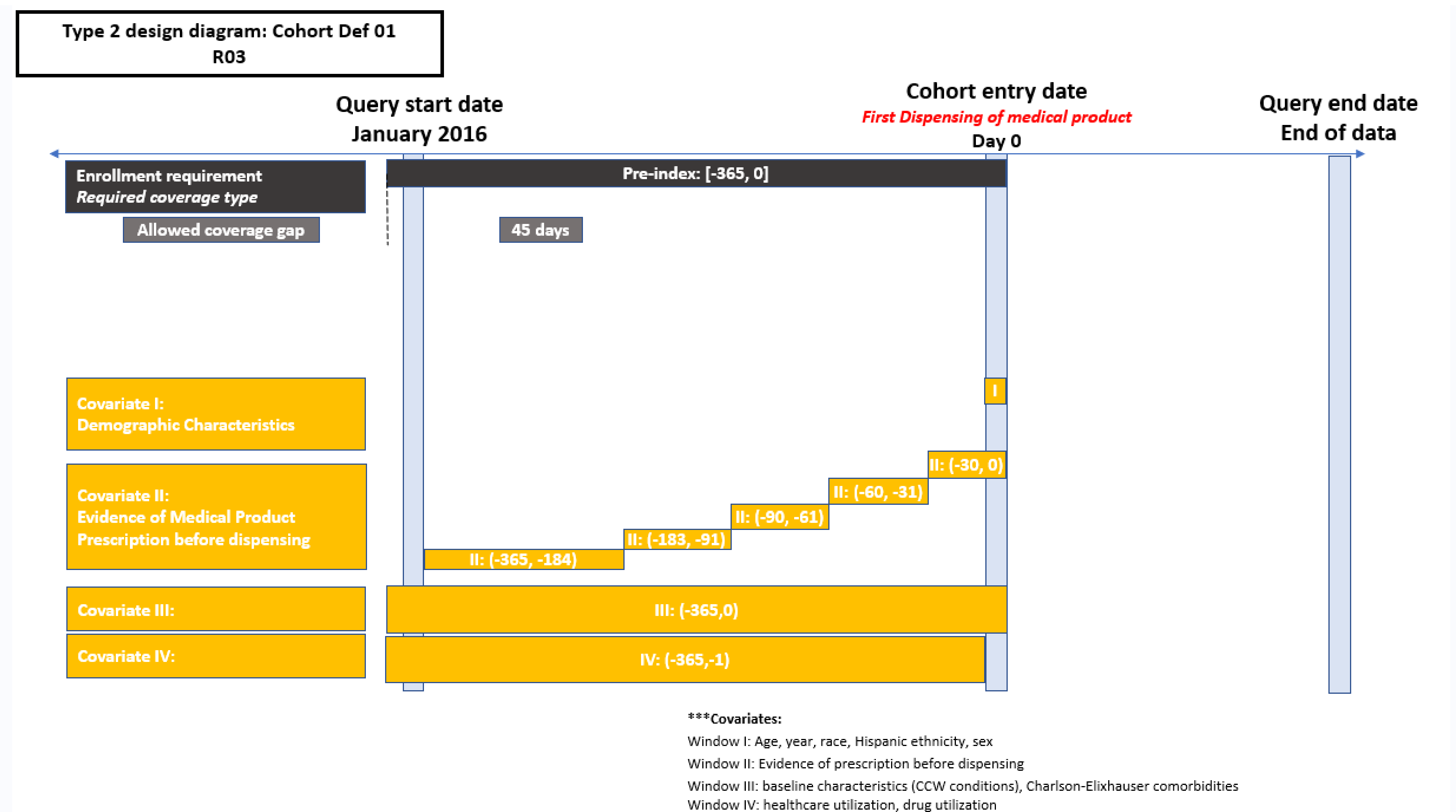
Covariate Name	Covariate Number	Code Category	Care Setting and Diagnosis Position Requirements	Covariate Evaluation Period Start	Covariate Evaluation Period End	Number of Instances the Covariate Should be Found in Evaluation Period	Lookback Period Date Only	Minimum Cumulative Number of Days *(only for CODECAT=RX)*
Atrial Fibrillation and Flutter	30	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Chronic Kidney Disease	31	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Chronic Obstructive Pulmonary Disease	32	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Depression, Bipolar, or Other Depressive Mood Disorders	33	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Diabetes	34	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Heart Failure and Non-Ischemic Heart Disease	35	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Hyperlipidemia	36	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Hypertension	37	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Ischemic Heart Disease	38	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Non-Alzheimer's Dementia	39	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	

Appendix F. Specifications Defining Baseline Characteristics for this Request (r03)

Baseline Characteristics								
Covariate Name	**Covariate Number**	**Code Category**	**Care Setting and Diagnosis Position Requirements**	**Covariate Evaluation Period Start**	**Covariate Evaluation Period End**	**Number of Instances the Covariate Should be Found in Evaluation Period**	**Lookback Period Date Only**	**Minimum Cumulative Number of Days *(only for CODECAT=RX)***
Parkinson's Disease and Secondary parkinsonism	40	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Pneumonia, All-cause	41	DX: Diagnosis code PX: Procedure code	Any CareSetting/Any Position	-365	0	1	N/A	
Stroke/Transient Ischemic Attack -inclusion	42	DX: Diagnosis code PX: Procedure code [will not be included in table output]	Any CareSetting/Any Position	-365	0	1	N/A	
Stroke/Transient Ischemic Attack -exclusion	43	DX: Diagnosis code PX: Procedure code [will not be included in table output]	Any CareSetting/Any Position	-365	0	1	N/A	
Stroke/Transient Ischemic Attack	44	cc: Covar 42 and not Covar 43	Any CareSetting/Any Position	-365	0	1	N/A	

N/A: Not applicable

Appendix G. Design Diagram of Cohort Entry Requirements, Index Exposure, and Event Outcome Assessment for the Prescribing Table (r03)



CCW: Chronic Conditions Data Warehouse