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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Overview for Requests: cder_mpl1r_wp284 & cder_mpl1p_wp094

Request ID: cder_mpl1r_wp284 & cder_mpl1p_wp094

Request Description: In this report we examined counts of individuals with clozapine use in the Sentinel Distributed Database (SDD), and examined evidence of Absolute Neutrophil Count (ANC) monitoring and occurrence of neutropenia among these individuals.

Sentinel Routine Querying Module: Cohort Identification and Descriptive Analysis (CIDA) module, version 13.1.2, with custom programming.

Data Source: Data for Tables 1a-1d and 3a-3b were obtained from a distribution of request cder_mpl1r_wp284 to 13 Sentinel Data Partners (DPs) on July 8, 2024. These 13 DPs are a subset of the SDD. Data from individuals having Medicare fee-for-service medical coverage, Medicare Part D drug coverage, and Medicaid coverage are included. Data for all other tables were obtained from distributing request cder_mpl1p_wp094 to eight Sentinel DPs on July 17, 2024. These DPs are a subset of the SDD that populate ANC laboratory results and do not include patients with fee-for-service Medicare coverage or Medicaid coverage. The study period for both requests included data from January 1, 2010 through January 1, 2024. Please see Appendix A for a list of dates of available data for each DP.

Study Design: In request cder_mpl1r_wp284, we identified individuals aged 12+ years with various definitions of clozapine incident use. In request cder_mpl1p_wp094, we identified these same individuals and also created successively more restrictive cohorts based upon the correspondence between ANC screening procedure codes and ANC laboratory results as well as upon the occurrence of various definitions of neutropenia in the first six months of the clozapine episode. These are Type 2 analyses in the Query Request Package (QRP) documentation.

Exposure of Interest: We defined the exposure of interest, clozapine, using outpatient dispensing data and National Drug Codes (NDCs). Each qualifying dispensing of clozapine (index) was identified for all male and female individuals aged 12+ years at index. We duplicated each cohort: one where cohort re-entry was allowed if subsequent valid index dates occured and the other where only the first valid index date was included (cohort re-entry not allowed). Please see Appendix B for a list of generic and brand names used to define the exposure of interest in this request.

Outcomes of Interest: We defined several outcomes of interest using eight definitions of neutropenia based on severity. These definitions include:

1) any neutropenia,
2) severe neutropenia (ANC laboratory result < 0.5 K/uL or "Other drug-induced agranulocytosis" diagnosis code),
3) severe neutropenia lab (ANC laboratory result <0.5 K/uL),
4) severe neutropenia diagnosis ("Other drug-induced agranulocytosis" diagnosis code),
5) moderate neutropenia without evidence of severe neutropenia (ANC laboratory result 0.5 K/uL - <1.0 K/uL),
6) moderate neutropenia regardless of severe neutropenia (ANC laboratory result 0.5 K/uL - <1.0 K/uL),
7) mild neutropenia without evidence of severe or moderate neutropenia (ANC laboratory result 1.0 K/uL - <1.5 K/uL), and
8) mild neutropenia regardless of severe or moderate neutropenia (ANC laboratory result 1.0 K/uL - <1.5 K/uL).

Please see Appendix C for a list of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and laboratory result codes used to define neutropenia in this report.

Overview for Requests: cder_mpl1r_wp284 & cder_mpl1p_wp094

Cohort Eligibility Criteria: We required members to be enrolled in health plans with medical and drug coverage for at least 183 days prior to their index date, during which gaps in coverage of up to 45 days were allowed. The following age groups were included in the cohort: 12-18, 19-35, 36-50, 51-64, 65-75, and 75+ years. We included two definitions of incident exposure: 1) no evidence of a clozapine dispensing in the previous 30 days, and 2) no evidence of a clozapine dispensing in the previous 183 days.

Inclusion Criteria: For entry into several of the cohorts, we required a complete correspondence between the occurrence of ANC screening procedure codes and ANC laboratory results, defined as at least as many ANC laboratory results during the clozapine exposure episodes as ANC screening procedure codes.

Follow-up Time: We created exposure episodes based on the number of days supplied in the outpatient pharmacy dispensing data. We bridged together episodes less than 30 days apart and added a 30-day extension to the end of each episode. These "as treated" episodes were truncated at 183 days in order to evaluate outcomes of interest during the first six months of exposure while exposed. Follow-up began on the day of the index dispensing and continued until the first occurrence of any of the following: 1) disenrollment; 2) death; 3) end of the data provided by each DP; 4) end of the query period; 5) end of the exposure episode (truncated at 183 days); or 6) occurrence of the outcome of interest.

Baseline Characteristics: We assessed age, sex, race, ethnicity, and year of index dispensing on the index date.

We assessed the following characteristics in the 183 days prior to the index date of clozapine dispensing: health service and drug utilization, anxiety, bipolar disorder, cardiovascular disorders, chronic kidney disease, chronic obstructive pulmonary disorder (COPD), depressive disorder, diabetes, post-traumatic stress disorder (PTSD), schizophrenia or schizoaffective disorder, substance use disorder, Crohn's disease, rheumatoid arthritis, chronic immune hepatitis, and systemic lupus erythematosus.

In cohorts where we evaluated a neutropenia outcome, we assessed the following characteristics in the 30 days prior to the outcome: chemotherapy and inpatient serious infection.

Also in cohorts where we evaluated a neutropenia outcome, we assessed the following characteristics from the date of the outcome through 30 days after: inpatient serious infection, antimicrobials, and filgrastim injections.

Finally, in cohorts where we evaluated a neutropenia outcome, we assessed ANC screenings in the week before, two weeks before, and one month before the outcome. We used these ANC screening characteristics to stratify the results.

We identified these characteristics by presence of a diagnosis or procedure code in any care setting (with the exception of inpatient serious infection), in any diagnosis position and used International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and ICD-10-CM diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) procedure Codes, National Drug Codes (NDC), and lab codes to define these conditions. Please see Appendix E for a list of generic and brand names of medical products and Appendix F for a list of diagnosis, procedure, and lab codes used to define characteristics in this request.

Overview for Requests: cder_mpl1r_wp284 & cder_mpl1p_wp094
Summary of Cohorts: Using the criteria specified above, we formed twelve separate cohort groups: 1. 13 DPs, 30-Day Washout, Cohort Re-entry Allowed (Baseline Characteristics) 2. 13 DPs, 30-Day Washout, Cohort Re-entry Not Allowed (Baseline Characteristics) 3. 8 DPs, 30-Day Washout, Cohort Re-entry Allowed (Baseline Characteristics) 4. 8 DPs, 30-Day Washout, Cohort Re-entry Not Allowed (Baseline Characteristics) 5. 8 DPs, 30-Day Washout, Cohort Re-entry Allowed, Complete Correspondence (Baseline Characteristics & Outcomes) 6. 8 DPs, 30-Day Washout, Cohort Re-entry Not Allowed, Complete Correspondence (Baseline Characteristics & Outcomes) 7. 13 DPs, 183-Day Washout, Cohort Re-entry Allowed (Baseline Characteristics) 8. 13 DPs, 183-Day Washout, Cohort Re-entry Not Allowed (Baseline Characteristics) 9. 8 DPs, 183-Day Washout, Cohort Re-entry Allowed (Baseline Characteristics) 10. 8 DPs, 183-Day Washout, Cohort Re-entry Not Allowed (Baseline Characteristics) 11. 8 DPs, 183-Day Washout, Cohort Re-entry Allowed, Complete Correspondence (Baseline Characteristics & Outcomes) 12. 8 DPs, 183-Day Washout, Cohort Re-entry Not Allowed, Complete Correspondence (Baseline Characteristics & Outcomes) **Limitations:** Algorithms to define exposures, outcomes, inclusion criteria, and characteristics are imperfect and may be misclassified. Therefore, data should be interpreted with this limitation in mind. **Notes:** Please contact the Sentinel Operations Center (info@sentinelsystem.org) for questions and to provide comments/suggestions for future enhancements to this document. For more information on Sentinel's routine querying modules, please refer to the documentation (https://dev.sentinelsystem.org/projects/SENTINEL/repos/sentinel-routine-querying-tool-documentation/browse).

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

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Appendix I Specifications Defining Baseline Characteristics for both Requests

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*Tables 1a-1d Represent Data from all 13 Data Partners

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.

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
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 with 30-Day Clozapine Washout, Cohort Re-entry Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Patient Characteristics[1]	Number	Percent
Unique patients	105,067	
Episodes	164,971	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	45.6	14.8
Age	**Number**	**Percent**
12-18 years	4,705	2.9%
19-35 years	49,926	30.3%
36-50 years	46,110	28.0%
51-64 years	43,114	26.1%
65-75 years	14,942	9.1%
≥ 75 years	6,174	3.7%
Sex		
Female	43,150	41.1%
Male	61,917	58.9%
Race[2]		
American Indian or Alaska Native	1,281	1.2%
Asian	2,908	2.8%
Black or African American	15,536	14.8%
Multi-racial	309	0.3%
Native Hawaiian or Other Pacific Islander	175	0.2%
Unknown	17,008	16.2%
White	67,850	64.6%
Hispanic origin		
Yes	6,731	6.4%
No	87,082	82.9%
Unknown	11,254	10.7%

Table 1a. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Demographic Characteristics	Number	Percent
Year		
2010	6,303	3.8%
2011	11,267	6.8%
2012	10,807	6.6%
2013	10,613	6.4%
2014	10,812	6.6%
2015	11,803	7.2%
2016	13,838	8.4%
2017	15,342	9.3%
2018	15,670	9.5%
2019	15,784	9.6%
2020	15,427	9.4%
2021	15,573	9.4%
2022	7,555	4.6%
2023	4,153	2.5%
2024	24	<0.1%
Health Characteristics Assessed [-183,-1] Days Prior to Clozapine Index		
Anxiety	59,463	36.0%
Bipolar Disorder	59,947	36.3%
Cardiovascular Disorder	22,424	13.6%
Chronic Kidney Disease	12,751	7.7%
Chronic Obstructive Pulmonary Disorder	23,851	14.5%
Depressive Disorder	55,449	33.6%
Diabetes	43,144	26.2%
Post-Traumatic Stress Disorder	12,796	7.8%
Schizophrenia or Schizoaffective Disorder	140,549	85.2%
Substance Use Disorder	36,327	22.0%
Crohn's Disease	544	0.3%
Rheumatoid Arthritis	6,793	4.1%
Chronic Autoimmune Hepatitis	2,109	1.3%
Systemic Lupus Erythematosus	109	0.1%

Table 1a. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Health Service Utilization Intensity Metrics Assessed [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	19.3	23.3
Mean number of emergency room encounters	1.1	2.5
Mean number of inpatient hospital encounters	0.6	1.2
Mean number of non-acute institutional encounters	0.7	1.2
Mean number of other ambulatory encounters	24.2	33.2
Mean number of filled prescriptions	31.1	27.3
Mean number of generics dispensed	9.0	6.1
Mean number of unique drug classes dispensed	8.3	5.5

*Tables 1a-1d Represent Data from all 13 Data Partners

[1]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

Table 1b. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Patient Characteristics[1]	Number	Percent
Unique patients	105,067	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	44.5	14.9
Age	**Number**	**Percent**
12-18 years	3,740	3.6%
19-35 years	33,962	32.3%
36-50 years	28,780	27.4%
51-64 years	26,214	24.9%
65-75 years	8,724	8.3%
≥ 75 years	3,647	3.5%
Sex		
Female	43,150	41.1%
Male	61,917	58.9%
Race[2]		
American Indian or Alaska Native	1,281	1.2%
Asian	2,908	2.8%
Black or African American	15,536	14.8%
Multi-racial	309	0.3%
Native Hawaiian or Other Pacific Islander	175	0.2%
Unknown	17,008	16.2%
White	67,850	64.6%
Hispanic origin		
Yes	6,731	6.4%
No	87,082	82.9%
Unknown	11,254	10.7%

Table 1b. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Demographic Characteristics	Number	Percent
Year		
2010	5,815	5.5%
2011	8,614	8.2%
2012	7,263	6.9%
2013	6,790	6.5%
2014	7,065	6.7%
2015	7,367	7.0%
2016	8,955	8.5%
2017	10,066	9.6%
2018	9,764	9.3%
2019	9,460	9.0%
2020	8,923	8.5%
2021	8,916	8.5%
2022	3,832	3.6%
2023	2,216	2.1%
2024	21	<0.1%
Health Characteristics Assessed [-183,-1] Days Prior to Clozapine Index		
Anxiety	39,689	37.8%
Bipolar Disorder	39,927	38.0%
Cardiovascular Disorder	13,565	12.9%
Chronic Kidney Disease	7,498	7.1%
Chronic Obstructive Pulmonary Disorder	14,508	13.8%
Depressive Disorder	36,949	35.2%
Diabetes	25,668	24.4%
Post-Traumatic Stress Disorder	9,078	8.6%
Schizophrenia or Schizoaffective Disorder	89,425	85.1%
Substance Use Disorder	25,273	24.1%
Crohn's Disease	351	0.3%
Rheumatoid Arthritis	4,246	4.0%
Chronic Autoimmune Hepatitis	1,412	1.3%
Systemic Lupus Erythematosus	76	0.1%

Table 1b. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Health Service Utilization Intensity Metrics Assessed [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	20.2	23.9
Mean number of emergency room encounters	1.2	2.6
Mean number of inpatient hospital encounters	0.6	1.3
Mean number of non-acute institutional encounters	0.7	1.2
Mean number of other ambulatory encounters	24.1	32.7
Mean number of filled prescriptions	32.6	28.4
Mean number of generics dispensed	9.1	6.3
Mean number of unique drug classes dispensed	8.4	5.6

*Tables 1a-1d Represent Data from all 13 Data Partners

[1]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

Table 1c. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Patient Characteristics[1]	Number	Percent
Unique patients	84,208	
Episodes	93,118	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	43.5	14.9
Age	**Number**	**Percent**
12-18 years	3,657	3.9%
19-35 years	32,306	34.7%
36-50 years	25,510	27.4%
51-64 years	21,479	23.1%
65-75 years	6,901	7.4%
≥ 75 years	3,265	3.5%
Sex		
Female	34,819	41.3%
Male	49,389	58.7%
Race[2]		
American Indian or Alaska Native	1,085	1.3%
Asian	2,372	2.8%
Black or African American	12,780	15.2%
Multi-racial	274	0.3%
Native Hawaiian or Other Pacific Islander	141	0.2%
Unknown	14,101	16.7%
White	53,455	63.5%
Hispanic origin		
Yes	5,599	6.6%
No	69,361	82.4%
Unknown	9,248	11.0%

Table 1c. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Demographic Characteristics	Number	Percent
Year		
2010	3,145	3.4%
2011	5,905	6.3%
2012	5,706	6.1%
2013	5,761	6.2%
2014	6,078	6.5%
2015	6,536	7.0%
2016	7,864	8.4%
2017	9,357	10.0%
2018	9,537	10.2%
2019	9,431	10.1%
2020	8,905	9.6%
2021	9,031	9.7%
2022	3,694	4.0%
2023	2,155	2.3%
2024	13	0.0%
Health Characteristics		
Anxiety	37,094	39.8%
Bipolar Disorder	36,925	39.7%
Cardiovascular Disorder	10,867	11.7%
Chronic Kidney Disease	6,182	6.6%
Chronic Obstructive Pulmonary Disorder	11,707	12.6%
Depressive Disorder	33,724	36.2%
Diabetes	21,178	22.7%
Post-Traumatic Stress Disorder	9,202	9.9%
Schizophrenia or Schizoaffective Disorder	78,547	84.4%
Substance Use Disorder	24,730	26.6%
Crohn's Disease	302	0.3%
Rheumatoid Arthritis	3,673	3.9%
Chronic Autoimmune Hepatitis	1,368	1.5%
Systemic Lupus Erythematosus	62	0.1%

Table 1c. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Health Service Utilization Intensity Metrics Assessed [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	20.8	24.9
Mean number of emergency room encounters	1.4	2.8
Mean number of inpatient hospital encounters	0.6	1.3
Mean number of non-acute institutional encounters	0.7	1.2
Mean number of other ambulatory encounters	24.8	34.0
Mean number of filled prescriptions	32.9	29.8
Mean number of generics dispensed	9.1	6.5
Mean number of unique drug classes dispensed	8.3	5.8

*Tables 1a-1d Represent Data from all 13 Data Partners

[1]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

Table 1d. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Patient Characteristics[1]	Number	Percent
Unique patients	84,208	N/A[2]
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	43.5	15.0
Age	**Number**	**Percent**
12-18 years	3,479	4.1%
19-35 years	29,231	34.7%
36-50 years	22,711	27.0%
51-64 years	19,315	22.9%
65-75 years	6,385	7.6%
≥ 75 years	3,087	3.7%
Sex		
Female	34,819	41.3%
Male	49,389	58.7%
Race[3]		
American Indian or Alaska Native	1,085	1.3%
Asian	2,372	2.8%
Black or African American	12,780	15.2%
Multi-racial	274	0.3%
Native Hawaiian or Other Pacific Islander	141	0.2%
Unknown	14,101	16.7%
White	53,455	63.5%
Hispanic origin		
Yes	5,599	6.6%
No	69,361	82.4%
Unknown	9,248	11.0%

Table 1d. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Demographic Characteristics	Number	Percent
Year		
2010	3,143	3.7%
2011	5,813	6.9%
2012	5,452	6.5%
2013	5,357	6.4%
2014	5,556	6.6%
2015	5,936	7.0%
2016	7,179	8.5%
2017	8,529	10.1%
2018	8,507	10.1%
2019	8,298	9.9%
2020	7,667	9.1%
2021	7,800	9.3%
2022	3,112	3.7%
2023	1,846	2.2%
2024	13	<0.1%
Health Characteristics		
Anxiety	33,868	40.2%
Bipolar Disorder	33,787	40.1%
Cardiovascular Disorder	9,970	11.8%
Chronic Kidney Disease	5,626	6.7%
Chronic Obstructive Pulmonary Disorder	10,546	12.5%
Depressive Disorder	30,959	36.8%
Diabetes	18,942	22.5%
Post-Traumatic Stress Disorder	8,340	9.9%
Schizophrenia or Schizoaffective Disorder	70,856	84.1%
Substance Use Disorder	22,367	26.6%
Crohn's Disease	273	0.3%
Rheumatoid Arthritis	3,380	4.0%
Chronic Autoimmune Hepatitis	1,223	1.5%
Systemic Lupus Erythematosus	59	0.1%

Table 1d. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024*

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	20.8	24.7
Mean number of emergency room encounters	1.4	2.8
Mean number of inpatient hospital encounters	0.6	1.3
Mean number of non-acute institutional encounters	0.7	1.2
Mean number of other ambulatory encounters	24.5	33.3
Mean number of filled prescriptions	33.2	29.6
Mean number of generics dispensed	9.2	6.5
Mean number of unique drug classes dispensed	8.4	5.7

*Tables 1a-1d Represent Data from all 13 Data Partners

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

[2]N/A: Not Applicable

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

Table 1e. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[1]	Number	Percent
Unique patients	6,698	
Episodes	10,473	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	46.3	16.5
Age	**Number**	**Percent**
12-18 years	346	3.3%
19-35 years	3,054	29.2%
36-50 years	2,721	26.0%
51-64 years	2,647	25.3%
65-75 years	1,185	11.3%
≥ 75 years	520	5.0%
Sex		
Female	2,989	44.6%
Male	3,709	55.4%
Race[2]		
American Indian or Alaska Native	28	0.4%
Asian	158	2.4%
Black or African American	600	9.0%
Multi-racial	52	0.8%
Native Hawaiian or Other Pacific Islander	32	0.5%
Unknown	2,208	33.0%
White	3,620	54.0%
Hispanic origin		
Yes	222	3.3%
No	4,394	65.6%
Unknown	2,082	31.1%

Table 1e. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Demographic Characteristics	Number	Percent
Year		
2010	483	4.6%
2011	*****	*****
2012	512	4.9%
2013	571	5.5%
2014	648	6.2%
2015	678	6.5%
2016	726	6.9%
2017	732	7.0%
2018	754	7.2%
2019	819	7.8%
2020	943	9.0%
2021	1,083	10.3%
2022	1,125	10.7%
2023	922	8.8%
2024	*****	*****
Health Characteristics Assessed [-183,-1] Days Prior to Clozapine Index		
Anxiety	4,173	39.8%
Bipolar Disorder	4,026	38.4%
Cardiovascular Disorder	1,029	9.8%
Chronic Kidney Disease	776	7.4%
Chronic Obstructive Pulmonary Disorder	1,086	10.4%
Depressive Disorder	3,694	35.3%
Diabetes	2,339	22.3%
Post-Traumatic Stress Disorder	897	8.6%
Schizophrenia or Schizoaffective Disorder	8,161	77.9%
Substance Use Disorder	2,096	20.0%
Crohn's Disease	27	0.3%
Rheumatoid Arthritis	547	5.2%
Chronic Autoimmune Hepatitis	70	0.7%
Systematic Lupus Erythematosus	*****	*****

Table 1e. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics Assessed [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	13.8	13.9
Mean number of emergency room encounters	1.1	2.9
Mean number of inpatient hospital encounters	0.7	2.1
Mean number of non-acute institutional encounters	0.4	0.9
Mean number of other ambulatory encounters	5.6	9.8
Mean number of filled prescriptions	25.2	21.8
Mean number of generics dispensed	8.5	5.9
Mean number of unique drug classes dispensed	7.9	5.3

[1]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

*****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.

Table 1f. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[1]	Number	
Unique patients	6,698	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	45.5	17.2
Age	**Number**	**Percent**
12-18 years	289	4.3%
19-35 years	2,048	30.6%
36-50 years	1,642	24.5%
51-64 years	1,658	24.8%
65-75 years	706	10.5%
≥ 75 years	355	5.3%
Sex		
Female	2,989	44.6%
Male	3,709	55.4%
Race[2]		
American Indian or Alaska Native	28	0.4%
Asian	158	2.4%
Black or African American	600	9.0%
Multi-racial	52	0.8%
Native Hawaiian or Other Pacific Islander	32	0.5%
Unknown	2,208	33.0%
White	3,620	54.0%
Hispanic origin		
Yes	222	3.3%
No	4,394	65.6%
Unknown	2,082	31.1%

Table 1f. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Demographic Characteristics	Number	Percent
Year		
2010	395	5.9%
2011	345	5.2%
2012	337	5.0%
2013	379	5.7%
2014	441	6.6%
2015	441	6.6%
2016	473	7.1%
2017	470	7.0%
2018	451	6.7%
2019	507	7.6%
2020	569	8.5%
2021	654	9.8%
2022	691	10.3%
2023	545	8.1%
2024	0	0.0%
Health Characteristics [-183, -1] Prior to Clozapine Index		
Anxiety	2,978	44.5%
Bipolar Disorder	2,773	41.4%
Cardiovascular Disorder	691	10.3%
Chronic Kidney Disease	475	7.1%
Chronic Obstructive Pulmonary Disorder	704	10.5%
Depressive Disorder	2,626	39.2%
Diabetes	1,414	21.1%
Post-Traumatic Stress Disorder	675	10.1%
Schizophrenia or Schizoaffective Disorder	5,269	78.7%
Substance Use Disorder	1,547	23.1%
Crohn's Disease	19	0.3%
Rheumatoid Arthritis	359	5.4%
Chronic Autoimmune Hepatitis	52	0.8%
Systematic Lupus Erythematosus	0	0.0%

Table 1f. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	14.1	14.0
Mean number of emergency room encounters	1.2	2.8
Mean number of inpatient hospital encounters	0.8	2.5
Mean number of non-acute institutional encounters	0.4	1.0
Mean number of other ambulatory encounters	5.6	9.9
Mean number of filled prescriptions	26.9	23.0
Mean number of generics dispensed	8.9	6.1
Mean number of unique drug classes dispensed	8.2	5.4

[1]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

Table 1g. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1], from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	1,595	
Episodes	2,223	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	45.1	15.0
Age	**Number**	**Percent**
12-18 years	56	2.5%
19-35 years	690	31.0%
36-50 years	616	27.7%
51-64 years	577	26.0%
65-75 years	220	9.9%
≥ 75 years	64	2.9%
Sex		
Female	675	42.3%
Male	920	57.7%
Race[3]		
American Indian or Alaska Native	*****	*****
Asian	42	2.6%
Black or African American	150	9.4%
Multi-racial	14	0.9%
Native Hawaiian or Other Pacific Islander	*****	*****
Unknown	439	27.5%
White	938	58.8%
Hispanic origin		
Yes	63	3.9%
No	1,160	72.7%
Unknown	372	23.3%

Table 1g. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1], from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Demographic Characteristics	Number	Percent
Year		
2010	54	2.4%
2011	73	3.3%
2012	97	4.4%
2013	107	4.8%
2014	128	5.8%
2015	147	6.6%
2016	155	7.0%
2017	158	7.1%
2018	165	7.4%
2019	202	9.1%
2020	210	9.4%
2021	234	10.5%
2022	252	11.3%
2023	241	10.8%
2024	0	0.0%
Health Characteristics [-183, -1] Prior to Clozapine Index		
Anxiety	801	36.0%
Bipolar Disorder	751	33.8%
Cardiovascular Disorder	164	7.4%
Chronic Kidney Disease	143	6.4%
Chronic Obstructive Pulmonary Disorder	211	9.5%
Depressive Disorder	754	33.9%
Diabetes	447	20.1%
Post-Traumatic Stress Disorder	164	7.4%
Schizophrenia or Schizoaffective Disorder	1,778	80.0%
Substance Use Disorder	421	18.9%
Crohn's Disease	*****	*****
Rheumatoid Arthritis	86	3.9%
Chronic Autoimmune Hepatitis	15	0.7%
Systematic Lupus Erythematosus	0	0.0%

Table 1g. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1], from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	12.2	12.0
Mean number of emergency room encounters	0.8	1.9
Mean number of inpatient hospital encounters	0.5	2.3
Mean number of non-acute institutional encounters	0.3	0.9
Mean number of other ambulatory encounters	6.6	9.1
Mean number of filled prescriptions	23.0	20.6
Mean number of generics dispensed	7.8	5.6
Mean number of unique drug classes dispensed	7.3	5.1

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

*****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.

Table 1h. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	50	
Episodes	53	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	41.2	13.9
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	24	45.3%
36-50 years	12	22.6%
51-64 years	13	24.5%
65-75 years	*****	*****
≥ 75 years	*****	*****
Sex		
Female	25	50.0%
Male	25	50.0%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	18	36.0%
White	22	44.0%
Hispanic origin		
Yes	*****	*****
No	33	66.0%
Unknown	*****	*****

Table 1h. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Demographic Characteristics	Number	Percent
Year		
2010	*****	*****
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	8	15.1%
2018	*****	*****
2019	*****	*****
2020	*****	*****
2021	*****	*****
2022	7	13.2%
2023	*****	*****
2024	0	0.0%
Health Characteristics [-183, -1] Prior to Clozapine Index		
Anxiety	18	34.0%
Bipolar Disorder	20	37.7%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	14	26.4%
Diabetes	10	18.9%
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	43	81.1%
Substance Use Disorder	14	26.4%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	*****	*****
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	9	17.0%
Filgrastim Injections	0	0.0%

Table 1h. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	Number/Mean	Percent/Standard Deviation[4]
ANC Screening Days -7 to -1	23	43.4%
ANC Screening Days -14 to -1	30	56.6%
ANC Screening Days -30 to -1	43	81.1%
Mean number of ANC screenings Days -7 to -1	0.5	0.7
Mean number of ANC screenings Days -14 to -1	0.9	0.9
Mean number of ANC screenings Days -30 to -1	2.1	1.6
Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index		
Mean number of ambulatory encounters	10.6	8.7
Mean number of emergency room encounters	0.6	1.1
Mean number of inpatient hospital encounters	0.8	1.1
Mean number of non-acute institutional encounters	0.3	0.7
Mean number of other ambulatory encounters	8.0	17.0
Mean number of filled prescriptions	23.2	16.5
Mean number of generics dispensed	8.2	6.0
Mean number of unique drug classes dispensed	7.5	5.3

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

*****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.

Table 1i. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	14	
Episodes	15	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	49.5	13.2
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	7	46.7%
65-75 years	0	0.0%
≥ 75 years	*****	*****
Sex		
Female	*****	*****
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	0	0.0%
White	9	64.3%
Hispanic origin		
Yes	0	0.0%
No	14	100.0%
Unknown	0	0.0%

Table 1i. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Demographic Characteristics	Number	Percent
Year		
2010	0	0.0%
2011	*****	*****
2012	0	0.0%
2013	0	0.0%
2014	0	0.0%
2015	*****	*****
2016	0	0.0%
2017	*****	*****
2018	*****	*****
2019	*****	*****
2020	*****	*****
2021	0	0.0%
2022	*****	*****
2023	*****	*****
2024	0	0.0%
Health Characteristics [-183, -1] Prior to Clozapine Index		
Anxiety	*****	*****
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	*****	*****
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	13	86.7%
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	*****	*****
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%

Table 1i. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	Number/Mean	Percent/Standard Deviation[4]
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	11	73.3%
Mean number of ANC screenings Days -7 to -1	0.3	0.4
Mean number of ANC screenings Days -14 to -1	0.5	0.6
Mean number of ANC screenings Days -30 to -1	1.4	1.1
Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters	10.1	4.9
Mean number of emergency room encounters	0.4	0.6
Mean number of inpatient hospital encounters	0.3	0.5
Mean number of non-acute institutional encounters	0.3	0.6
Mean number of other ambulatory encounters	5.0	4.4
Mean number of filled prescriptions	30.0	18.6
Mean number of generics dispensed	9.4	4.4
Mean number of unique drug classes dispensed	8.7	4.2

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1j. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	6	
Episodes	6	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	37.0	14.3
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	0	0.0%
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	*****	*****
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	*****	*****
White	*****	*****
Hispanic origin		
Yes	*****	*****
No	*****	*****
Unknown	*****	*****
Year		
2010	0	0.0%
2011	0	0.0%
2012	0	0.0%
2013	*****	*****
2014	0	0.0%
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	*****	*****
2022	0	0.0%
2023	0	0.0%
2024	0	0.0%

Table 1j. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	0	0.0%
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	0	0.0%
Depressive Disorder	*****	*****
Diabetes	*****	*****
Post-Traumatic Stress Disorder	0	0.0%
Schizophrenia or Schizoaffective Disorder	*****	*****
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	0	0.0%
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	0	0.0%
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	*****	*****
Mean number of ANC screenings Days -7 to -1	0.5	0.4
Mean number of ANC screenings Days -14 to -1	1.0	0.7
Mean number of ANC screenings Days -30 to -1	1.7	1.4

Table 1j. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	12.3	11.9
Mean number of emergency room encounters	0.5	0.4
Mean number of inpatient hospital encounters	1.5	0.0
Mean number of non-acute institutional encounters	0.5	1.1
Mean number of other ambulatory encounters	1.7	0.4
Mean number of filled prescriptions	9.3	11.0
Mean number of generics dispensed	3.5	3.6
Mean number of unique drug classes dispensed	3.2	2.9

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1k. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	8	
Episodes	8	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	42.6	15.8
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	*****	*****
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	*****	*****
White	*****	*****
Hispanic origin		
Yes	*****	*****
No	*****	*****
Unknown	*****	*****
Year		
2010	0	0.0%
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	0	0.0%
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	*****	*****
2022	*****	*****
2023	0	0.0%
2024	0	0.0%

Table 1k. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index		
Anxiety	*****	*****
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	0	0.0%
Depressive Disorder	*****	*****
Diabetes	*****	*****
Post-Traumatic Stress Disorder	0	0.0%
Schizophrenia or Schizoaffective Disorder	7	87.5%
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	0	0.0%
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	*****	*****
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	*****	*****
Mean number of ANC screenings Days -7 to -1	1.4	2.4
Mean number of ANC screenings Days -14 to -1	2.8	4.8
Mean number of ANC screenings Days -30 to -1	4.6	8.1

Table 1k. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	13.4	11.2
Mean number of emergency room encounters	0.8	0.6
Mean number of inpatient hospital encounters	1.3	0.0
Mean number of non-acute institutional encounters	0.5	1.0
Mean number of other ambulatory encounters	4.5	5.9
Mean number of filled prescriptions	21.0	27.2
Mean number of generics dispensed	7.6	8.1
Mean number of unique drug classes dispensed	6.6	6.9

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1l. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	31	
Episodes	32	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	38.1	13.7
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	18	56.3%
36-50 years	6	18.8%
51-64 years	*****	*****
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	15	48.4%
Male	16	51.6%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	15	48.4%
White	12	38.7%
Hispanic origin		
Yes	*****	*****
No	17	54.8%
Unknown	*****	*****
Year		
2010	*****	*****
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	0	0.0%
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1l. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	13	40.6%
Bipolar Disorder	13	40.6%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	9	28.1%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	25	78.1%
Substance Use Disorder	9	28.1%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	16	50.0%
ANC Screening Days -14 to -1	22	68.8%
ANC Screening Days -30 to -1	29	90.6%
Mean number of ANC screenings Days -7 to -1	0.7	0.8
Mean number of ANC screenings Days -14 to -1	1.2	1.0
Mean number of ANC screenings Days -30 to -1	2.6	1.7

Table 1l. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	10.6	9.1
Mean number of emergency room encounters	0.8	1.3
Mean number of inpatient hospital encounters	0.9	1.4
Mean number of non-acute institutional encounters	0.3	0.7
Mean number of other ambulatory encounters	10.6	20.9
Mean number of filled prescriptions	22.5	14.8
Mean number of generics dispensed	8.6	6.3
Mean number of unique drug classes dispensed	7.8	5.6

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1m. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	33	
Episodes	34	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	37.3	13.7
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	20	58.8%
36-50 years	6	17.6%
51-64 years	*****	*****
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	15	45.5%
Male	18	54.5%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	16	48.5%
White	12	36.4%
Hispanic origin		
Yes	*****	*****
No	18	54.5%
Unknown	*****	*****
Year		
2010	*****	*****
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	0	0.0%
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1m. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	13	38.2%
Bipolar Disorder	14	41.2%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	9	26.5%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	27	79.4%
Substance Use Disorder	10	29.4%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	6	17.6%
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	18	52.9%
ANC Screening Days -14 to -1	24	70.6%
ANC Screening Days -30 to -1	31	91.2%
Mean number of ANC screenings Days -7 to -1	0.7	0.8
Mean number of ANC screenings Days -14 to -1	1.1	0.9
Mean number of ANC screenings Days -30 to -1	2.6	1.7

Table 1m. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	10.2	9.0
Mean number of emergency room encounters	0.8	1.3
Mean number of inpatient hospital encounters	1.1	1.4
Mean number of non-acute institutional encounters	0.3	0.7
Mean number of other ambulatory encounters	10.3	20.6
Mean number of filled prescriptions	21.8	14.5
Mean number of generics dispensed	8.3	6.2
Mean number of unique drug classes dispensed	7.6	5.5

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1n. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1], from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	1,595	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	43.8	15.5
Age	**Number**	**Percent**
12-18 years	50	3.1%
19-35 years	546	34.2%
36-50 years	429	26.9%
51-64 years	391	24.5%
65-75 years	132	8.3%
≥ 75 years	47	2.9%
Sex		
Female	675	42.3%
Male	920	57.7%
Race[3]		
American Indian or Alaska Native	*****	*****
Asian	42	2.6%
Black or African American	150	9.4%
Multi-racial	14	0.9%
Native Hawaiian or Other Pacific Islander	*****	*****
Unknown	439	27.5%
White	938	58.8%
Hispanic origin		
Yes	63	3.9%
No	1,160	72.7%
Unknown	372	23.3%
Year		
2010	50	3.1%
2011	63	3.9%
2012	76	4.8%
2013	85	5.3%
2014	94	5.9%
2015	100	6.3%
2016	105	6.6%
2017	106	6.6%
2018	121	7.6%
2019	137	8.6%
2020	146	9.2%
2021	163	10.2%
2022	191	12.0%
2023	158	9.9%
2024	0	0.0%

Table 1n. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1], from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	639	40.1%
Bipolar Disorder	601	37.7%
Cardiovascular Disorder	118	7.4%
Chronic Kidney Disease	102	6.4%
Chronic Obstructive Pulmonary Disorder	145	9.1%
Depressive Disorder	573	35.9%
Diabetes	303	19.0%
Post-Traumatic Stress Disorder	130	8.2%
Schizophrenia or Schizoaffective Disorder	1,267	79.4%
Substance Use Disorder	348	21.8%
Crohn's Disease	*****	*****
Rheumatoid Arthritis	64	4.0%
Chronic Autoimmune Hepatitis	13	0.8%
Systematic Lupus Erythematosus	0	0.0%
Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters	12.7	12.6
Mean number of emergency room encounters	1.0	2.1
Mean number of inpatient hospital encounters	0.7	2.6
Mean number of non-acute institutional encounters	0.3	0.9
Mean number of other ambulatory encounters	6.8	9.3
Mean number of filled prescriptions	24.7	21.7
Mean number of generics dispensed	8.3	5.9
Mean number of unique drug classes dispensed	7.7	5.3

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

*****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.

Table 1o. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	43	N/A[3]
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	40.5	13.6
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	20	46.5%
36-50 years	9	20.9%
51-64 years	11	25.6%
65-75 years	*****	*****
≥ 75 years	*****	*****
Sex		
Female	21	48.8%
Male	22	51.2%
Race[4]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	18	41.9%
White	18	41.9%
Hispanic origin		
Yes	*****	*****
No	26	60.5%
Unknown	*****	*****
Year		
2010	*****	*****
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	6	14.0%
2018	*****	*****
2019	*****	*****
2020	*****	*****
2021	*****	*****
2022	6	14.0%
2023	*****	*****
2024	0	0.0%

Table 1o. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	17	39.5%
Bipolar Disorder	19	44.2%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	12	27.9%
Diabetes	8	18.6%
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	34	79.1%
Substance Use Disorder	11	25.6%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	7	16.3%
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[5]**
ANC Screening Days -7 to -1	21	48.8%
ANC Screening Days -14 to -1	28	65.1%
ANC Screening Days -30 to -1	39	90.7%
Mean number of ANC screenings Days -7 to -1	0.6	0.7
Mean number of ANC screenings Days -14 to -1	1.0	0.9
Mean number of ANC screenings Days -30 to -1	2.2	1.6

Table 1o. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	10.1	7.9
Mean number of emergency room encounters	0.7	1.2
Mean number of inpatient hospital encounters	0.9	1.2
Mean number of non-acute institutional encounters	0.4	0.8
Mean number of other ambulatory encounters	6.5	5.5
Mean number of filled prescriptions	23.2	16.9
Mean number of generics dispensed	8.3	5.8
Mean number of unique drug classes dispensed	7.6	5.2

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

[3]N/A: Not Applicable

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

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

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Table 1p. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	11	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	50.5	11.3
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	0	0.0%
≥ 75 years	*****	*****
Sex		
Female	*****	*****
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	*****	*****
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	11	100.0%
Unknown	0	0.0%
Year		
2010	0	0.0%
2011	*****	*****
2012	0	0.0%
2013	0	0.0%
2014	0	0.0%
2015	*****	*****
2016	0	0.0%
2017	*****	*****
2018	*****	*****
2019	*****	*****
2020	0	0.0%
2021	0	0.0%
2022	*****	*****
2023	0	0.0%
2024	0	0.0%

Table 1p. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	*****	*****
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	*****	*****
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	9	81.8%
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	9	81.8%
Mean number of ANC screenings Days -7 to -1	0.3	0.3
Mean number of ANC screenings Days -14 to -1	0.5	0.4
Mean number of ANC screenings Days -30 to -1	1.5	0.8

Table 1p. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	12.5	5.2
Mean number of emergency room encounters	0.5	0.6
Mean number of inpatient hospital encounters	0.1	0.0
Mean number of non-acute institutional encounters	0.4	0.6
Mean number of other ambulatory encounters	5.3	4.7
Mean number of filled prescriptions	33.6	18.4
Mean number of generics dispensed	10.6	4.1
Mean number of unique drug classes dispensed	9.7	3.8

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1q. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	*****	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	30.1	0.0
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	0	0.0%
65-75 years	0	0.0%
≥ 75 years	0	0.0%
Sex		
Female	0	0.0%
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	*****	*****
White	0	0.0%
Hispanic origin		
Yes	*****	*****
No	*****	*****
Unknown	*****	*****
Year		
2010	0	0.0%
2011	0	0.0%
2012	0	0.0%
2013	*****	*****
2014	0	0.0%
2015	*****	*****
2016	*****	*****
2017	0	0.0%
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	*****	*****
2022	0	0.0%
2023	0	0.0%
2024	0	0.0%

Table 1q. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	0	0.0%
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	0	0.0%
Depressive Disorder	0	0.0%
Diabetes	0	0.0%
Post-Traumatic Stress Disorder	0	0.0%
Schizophrenia or Schizoaffective Disorder	*****	*****
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	0	0.0%
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	0	0.0%
Filgrastim Injections	0	0.0%

Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	Number/Mean	Percent/Standard Deviation[4]
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	*****	*****
Mean number of ANC screenings Days -7 to -1	0.8	0.0
Mean number of ANC screenings Days -14 to -1	1.5	0.0
Mean number of ANC screenings Days -30 to -1	2.5	0.0

Table 1q. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	7.8	0.0
Mean number of emergency room encounters	0.8	0.0
Mean number of inpatient hospital encounters	2.3	0.0
Mean number of non-acute institutional encounters	0.8	0.0
Mean number of other ambulatory encounters	2.5	0.0
Mean number of filled prescriptions	5.5	0.0
Mean number of generics dispensed	2.3	0.0
Mean number of unique drug classes dispensed	2.3	0.0

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1r. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	6	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	39.8	13.8
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	0	0.0%
≥ 75 years	0	0.0%
Sex		
Female	*****	*****
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	*****	*****
White	*****	*****
Hispanic origin		
Yes	*****	*****
No	*****	*****
Unknown	*****	*****
Year		
2010	0	0.0%
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	0	0.0%
2015	*****	*****
2016	*****	*****
2017	0	0.0%
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	*****	*****
2022	*****	*****
2023	0	0.0%
2024	0	0.0%

Table 1r. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	*****	*****
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	0	0.0%
Depressive Disorder	*****	*****
Diabetes	*****	*****
Post-Traumatic Stress Disorder	0	0.0%
Schizophrenia or Schizoaffective Disorder	*****	*****
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	0	0.0%
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	*****	*****
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	*****	*****
Mean number of ANC screenings Days -7 to -1	1.8	2.1
Mean number of ANC screenings Days -14 to -1	3.7	4.2
Mean number of ANC screenings Days -30 to -1	6.2	7.1

Table 1r. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	10.7	2.0
Mean number of emergency room encounters	1.0	0.4
Mean number of inpatient hospital encounters	1.7	0.0
Mean number of non-acute institutional encounters	0.7	0.7
Mean number of other ambulatory encounters	6.0	5.7
Mean number of filled prescriptions	22.3	30.2
Mean number of generics dispensed	8.2	9.1
Mean number of unique drug classes dispensed	7.2	7.6

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1s. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	28	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	38.0	13.7
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	16	57.1%
36-50 years	*****	*****
51-64 years	6	21.4%
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	14	50.0%
Male	14	50.0%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	15	53.6%
White	9	32.1%
Hispanic origin		
Yes	*****	*****
No	14	50.0%
Unknown	13	46.4%
Year		
2010	*****	*****
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	0	0.0%
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1s. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	13	46.4%
Bipolar Disorder	12	42.9%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	9	32.1%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	22	78.6%
Substance Use Disorder	7	25.0%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	15	53.6%
ANC Screening Days -14 to -1	21	75.0%
ANC Screening Days -30 to -1	27	96.4%
Mean number of ANC screenings Days -7 to -1	0.7	0.8
Mean number of ANC screenings Days -14 to -1	1.2	0.9
Mean number of ANC screenings Days -30 to -1	2.5	1.7

Table 1s. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	9.6	8.9
Mean number of emergency room encounters	0.8	1.3
Mean number of inpatient hospital encounters	1.0	1.4
Mean number of non-acute institutional encounters	0.3	0.7
Mean number of other ambulatory encounters	7.5	5.7
Mean number of filled prescriptions	21.6	14.1
Mean number of generics dispensed	8.3	5.6
Mean number of unique drug classes dispensed	7.6	5.1

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1t. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	30	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	37.1	13.6
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	18	60.0%
36-50 years	*****	*****
51-64 years	6	20.0%
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	14	46.7%
Male	16	53.3%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	16	53.3%
White	9	30.0%
Hispanic origin		
Yes	*****	*****
No	15	50.0%
Unknown	*****	*****
Year		
2010	*****	*****
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	0	0.0%
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1t. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	13	43.3%
Bipolar Disorder	13	43.3%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	9	30.0%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	24	80.0%
Substance Use Disorder	8	26.7%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	17	56.7%
ANC Screening Days -14 to -1	23	76.7%
ANC Screening Days -30 to -1	29	96.7%
Mean number of ANC screenings Days -7 to -1	0.7	0.8
Mean number of ANC screenings Days -14 to -1	1.2	0.9
Mean number of ANC screenings Days -30 to -1	2.5	1.7

Table 1t. Aggregated Characteristics of Patients with 30-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	9.3	8.7
Mean number of emergency room encounters	0.8	1.3
Mean number of inpatient hospital encounters	1.2	1.4
Mean number of non-acute institutional encounters	0.3	0.7
Mean number of other ambulatory encounters	7.3	5.8
Mean number of filled prescriptions	20.9	13.9
Mean number of generics dispensed	8.0	5.5
Mean number of unique drug classes dispensed	7.3	5.0

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

*****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.

Table 1u. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[1]	Number	Percent
Unique patients	5,306	
Episodes	5,647	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	44.6	17.6
Age	**Number**	**Percent**
12-18 years	279	4.9%
19-35 years	1,886	33.4%
36-50 years	1,292	22.9%
51-64 years	1,297	23.0%
65-75 years	550	9.7%
≥ 75 years	343	6.1%
Sex		
Female	2,386	45.0%
Male	2,920	55.0%
Race[2]		
American Indian or Alaska Native	26	0.5%
Asian	130	2.5%
Black or African American	451	8.5%
Multi-racial	47	0.9%
Native Hawaiian or Other Pacific Islander	22	0.4%
Unknown	1,785	33.6%
White	2,845	53.6%
Hispanic origin		
Yes	186	3.5%
No	3,435	64.7%
Unknown	1,685	31.8%
Year		
2010	249	4.4%
2011	277	4.9%
2012	280	5.0%
2013	311	5.5%
2014	358	6.3%
2015	382	6.8%
2016	419	7.4%
2017	415	7.3%
2018	409	7.2%
2019	448	7.9%
2020	494	8.7%
2021	562	10.0%
2022	579	10.3%
2023	464	8.2%
2024	0	0.0%

Table 1u. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	2,701	47.8%
Bipolar Disorder	2,465	43.7%
Cardiovascular Disorder	581	10.3%
Chronic Kidney Disease	396	7.0%
Chronic Obstructive Pulmonary Disorder	540	9.6%
Depressive Disorder	2,354	41.7%
Diabetes	1,076	19.1%
Post-Traumatic Stress Disorder	648	11.5%
Schizophrenia or Schizoaffective Disorder	4,415	78.2%
Substance Use Disorder	1,452	25.7%
Crohn's Disease	15	0.3%
Rheumatoid Arthritis	313	5.5%
Chronic Autoimmune Hepatitis	51	0.9%
Systematic Lupus Erythematosus	*****	*****
Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters	14.4	14.5
Mean number of emergency room encounters	1.4	3.0
Mean number of inpatient hospital encounters	0.9	2.4
Mean number of non-acute institutional encounters	0.5	1.0
Mean number of other ambulatory encounters	5.7	9.9
Mean number of filled prescriptions	27.0	23.9
Mean number of generics dispensed	8.9	6.3
Mean number of unique drug classes dispensed	8.2	5.7

[1]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

*****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.

Table 1v. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[1]	Number	
Unique patients	5,306	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	44.6	17.7
Age	**Number**	**Percent**
12-18 years	271	5.1%
19-35 years	1,760	33.2%
36-50 years	1,210	22.8%
51-64 years	1,219	23.0%
65-75 years	523	9.9%
≥ 75 years	323	6.1%
Sex		
Female	2,386	45.0%
Male	2,920	55.0%
Race[2]		
American Indian or Alaska Native	26	0.5%
Asian	130	2.5%
Black or African American	451	8.5%
Multi-racial	47	0.9%
Native Hawaiian or Other Pacific Islander	22	0.4%
Unknown	1,785	33.6%
White	2,845	53.6%
Hispanic origin		
Yes	186	3.5%
No	3,435	64.7%
Unknown	1,685	31.8%
Year		
2010	249	4.7%
2011	274	5.2%
2012	270	5.1%
2013	297	5.6%
2014	342	6.4%
2015	363	6.8%
2016	392	7.4%
2017	388	7.3%
2018	380	7.2%
2019	413	7.8%
2020	458	8.6%
2021	523	9.9%
2022	531	10.0%
2023	426	8.0%
2024	0	0.0%

Table 1v. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	2,565	48.3%
Bipolar Disorder	2,352	44.3%
Cardiovascular Disorder	557	10.5%
Chronic Kidney Disease	368	6.9%
Chronic Obstructive Pulmonary Disorder	512	9.6%
Depressive Disorder	2,259	42.6%
Diabetes	1,017	19.2%
Post-Traumatic Stress Disorder	616	11.6%
Schizophrenia or Schizoaffective Disorder	4,138	78.0%
Substance Use Disorder	1,380	26.0%
Crohn's Disease	14	0.3%
Rheumatoid Arthritis	302	5.7%
Chronic Autoimmune Hepatitis	49	0.9%
Systematic Lupus Erythematosus	0	0.0%
Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters	14.4	14.4
Mean number of emergency room encounters	1.4	2.9
Mean number of inpatient hospital encounters	0.9	2.4
Mean number of non-acute institutional encounters	0.5	1.0
Mean number of other ambulatory encounters	5.7	9.9
Mean number of filled prescriptions	27.4	23.8
Mean number of generics dispensed	9.1	6.3
Mean number of unique drug classes dispensed	8.3	5.6

[1]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

Table 1w. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1], from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	1,053	
Episodes	1,087	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	42.7	15.9
Age	**Number**	**Percent**
12-18 years	44	4.0%
19-35 years	395	36.3%
36-50 years	279	25.7%
51-64 years	256	23.6%
65-75 years	69	6.3%
≥ 75 years	44	4.0%
Sex		
Female	452	42.9%
Male	601	57.1%
Race[3]		
American Indian or Alaska Native	*****	*****
Asian	29	2.8%
Black or African American	87	8.3%
Multi-racial	11	1.0%
Native Hawaiian or Other Pacific Islander	*****	*****
Unknown	292	27.7%
White	626	59.4%
Hispanic origin		
Yes	50	4.7%
No	770	73.1%
Unknown	233	22.1%
Year		
2010	28	2.6%
2011	40	3.7%
2012	59	5.4%
2013	49	4.5%
2014	62	5.7%
2015	67	6.2%
2016	85	7.8%
2017	76	7.0%
2018	83	7.6%
2019	101	9.3%
2020	106	9.8%
2021	109	10.0%
2022	117	10.8%
2023	105	9.7%
2024	0	0.0%

Table 1w. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1], from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	498	45.8%
Bipolar Disorder	441	40.6%
Cardiovascular Disorder	82	7.5%
Chronic Kidney Disease	73	6.7%
Chronic Obstructive Pulmonary Disorder	87	8.0%
Depressive Disorder	446	41.0%
Diabetes	178	16.4%
Post-Traumatic Stress Disorder	110	10.1%
Schizophrenia or Schizoaffective Disorder	868	79.9%
Substance Use Disorder	279	25.7%
Crohn's Disease	*****	*****
Rheumatoid Arthritis	46	4.2%
Chronic Autoimmune Hepatitis	13	1.2%
Systematic Lupus Erythematosus	0	0.0%
Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters	13.3	13.2
Mean number of emergency room encounters	1.2	2.2
Mean number of inpatient hospital encounters	0.8	1.5
Mean number of non-acute institutional encounters	0.4	1.0
Mean number of other ambulatory encounters	7.2	9.6
Mean number of filled prescriptions	25.5	23.4
Mean number of generics dispensed	8.6	6.3
Mean number of unique drug classes dispensed	7.9	5.6

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

*****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.

Table 1x. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	31	
Episodes	33	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	39.0	14.1
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	18	54.5%
36-50 years	*****	*****
51-64 years	9	27.3%
65-75 years	*****	*****
≥ 75 years	*****	*****
Sex		
Female	15	48.4%
Male	16	51.6%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	12	38.7%
White	13	41.9%
Hispanic origin		
Yes	*****	*****
No	20	64.5%
Unknown	*****	*****
Year		
2010	*****	*****
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	*****	*****
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1x. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	17	51.5%
Bipolar Disorder	15	45.5%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	9	27.3%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	27	81.8%
Substance Use Disorder	11	33.3%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	*****	*****
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	8	24.2%
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	19	57.6%
ANC Screening Days -14 to -1	25	75.8%
ANC Screening Days -30 to -1	29	87.9%
Mean number of ANC screenings Days -7 to -1	0.6	0.7
Mean number of ANC screenings Days -14 to -1	1.2	0.9
Mean number of ANC screenings Days -30 to -1	2.4	1.6

Table 1x. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	10.7	9.1
Mean number of emergency room encounters	0.8	1.2
Mean number of inpatient hospital encounters	1.0	1.1
Mean number of non-acute institutional encounters	0.5	0.8
Mean number of other ambulatory encounters	6.0	5.5
Mean number of filled prescriptions	24.4	18.4
Mean number of generics dispensed	8.6	6.3
Mean number of unique drug classes dispensed	8.0	5.7

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1y. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	7	
Episodes	8	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	55.2	9.7
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	0	0.0%
≥ 75 years	*****	*****
Sex		
Female	*****	*****
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
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	7	100.0%
Unknown	0	0.0%
Year		
2010	0	0.0%
2011	*****	*****
2012	0	0.0%
2013	0	0.0%
2014	0	0.0%
2015	0	0.0%
2016	0	0.0%
2017	*****	*****
2018	*****	*****
2019	*****	*****
2020	0	0.0%
2021	0	0.0%
2022	*****	*****
2023	0	0.0%
2024	0	0.0%

Table 1y. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	*****	*****
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	*****	*****
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	8	100.0%
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	*****	*****
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	6	75.0%
Mean number of ANC screenings Days -7 to -1	0.5	0.3
Mean number of ANC screenings Days -14 to -1	1.0	0.4
Mean number of ANC screenings Days -30 to -1	2.0	0.9

Table 1y. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	11.5	5.2
Mean number of emergency room encounters	0.5	0.7
Mean number of inpatient hospital encounters	0.4	0.0
Mean number of non-acute institutional encounters	0.5	0.6
Mean number of other ambulatory encounters	7.4	5.1
Mean number of filled prescriptions	36.4	18.7
Mean number of generics dispensed	11.1	4.5
Mean number of unique drug classes dispensed	10.3	3.9

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

*****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.

Table 1z. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	*****	
Episodes	*****	*****
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	30.0	2.7
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	0	0.0%
65-75 years	0	0.0%
≥ 75 years	0	0.0%
Sex		
Female	*****	*****
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	*****	*****
White	0	0.0%
Hispanic origin		
Yes	*****	*****
No	*****	*****
Unknown	*****	*****
Year		
2010	0	0.0%
2011	0	0.0%
2012	0	0.0%
2013	*****	*****
2014	0	0.0%
2015	*****	*****
2016	*****	*****
2017	0	0.0%
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	*****	*****
2022	0	0.0%
2023	0	0.0%
2024	0	0.0%

Table 1z. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	0	0.0%
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	0	0.0%
Depressive Disorder	0	0.0%
Diabetes	0	0.0%
Post-Traumatic Stress Disorder	0	0.0%
Schizophrenia or Schizoaffective Disorder	*****	*****
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	0	0.0%
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	0	0.0%
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	*****	*****
Mean number of ANC screenings Days -7 to -1	0.6	0.0
Mean number of ANC screenings Days -14 to -1	1.2	0.0
Mean number of ANC screenings Days -30 to -1	2.0	0.0

Table 1z. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	13.0	11.3
Mean number of emergency room encounters	0.6	0.0
Mean number of inpatient hospital encounters	1.8	0.0
Mean number of non-acute institutional encounters	0.6	0.0
Mean number of other ambulatory encounters	2.0	0.4
Mean number of filled prescriptions	4.8	0.7
Mean number of generics dispensed	2.0	0.4
Mean number of unique drug classes dispensed	2.0	0.4

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

*****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.

Table 1aa. Aggregated Characteristics of 183-Day Clozapine Washout Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with ANC Laboratory Results in the Sentinel Distributed Database from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	7	
Episodes	7	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	38.4	14.1
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	0	0.0%
≥ 75 years	0	0.0%
Sex		
Female	*****	*****
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	*****	*****
White	*****	*****
Hispanic origin		
Yes	*****	*****
No	*****	*****
Unknown	*****	*****
Year		
2010	0	0.0%
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	0	0.0%
2015	*****	*****
2016	*****	*****
2017	0	0.0%
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	*****	*****
2022	*****	*****
2023	0	0.0%
2024	0	0.0%

Table 1aa. Aggregated Characteristics of 183-Day Clozapine Washout Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with ANC Laboratory Results in the Sentinel Distributed Database from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	*****	*****
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	0	0.0%
Depressive Disorder	*****	*****
Diabetes	*****	*****
Post-Traumatic Stress Disorder	0	0.0%
Schizophrenia or Schizoaffective Disorder	6	85.7%
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	0	0.0%
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	*****	*****
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	*****	*****
Mean number of ANC screenings Days -7 to -1	1.6	2.1
Mean number of ANC screenings Days -14 to -1	3.1	4.2
Mean number of ANC screenings Days -30 to -1	5.3	7.1

Table 1aa. Aggregated Characteristics of 183-Day Clozapine Washout Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with ANC Laboratory Results in the Sentinel Distributed Database from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	14.0	11.5
Mean number of emergency room encounters	0.9	0.4
Mean number of inpatient hospital encounters	1.4	0.0
Mean number of non-acute institutional encounters	0.6	0.7
Mean number of other ambulatory encounters	5.1	5.7
Mean number of filled prescriptions	19.4	30.2
Mean number of generics dispensed	7.1	9.1
Mean number of unique drug classes dispensed	6.3	7.7

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1ab. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	20	
Episodes	20	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	34.7	13.3
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	13	65.0%
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	11	55.0%
Male	9	45.0%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	9	45.0%
White	7	35.0%
Hispanic origin		
Yes	*****	*****
No	12	60.0%
Unknown	*****	*****
Year		
2010	*****	*****
2011	0	0.0%
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	0	0.0%
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1ab. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	12	60.0%
Bipolar Disorder	10	50.0%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	7	35.0%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	15	75.0%
Substance Use Disorder	7	35.0%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	12	60.0%
ANC Screening Days -14 to -1	17	85.0%
ANC Screening Days -30 to -1	20	100.0%
Mean number of ANC screenings Days -7 to -1	0.7	0.8
Mean number of ANC screenings Days -14 to -1	1.4	0.8
Mean number of ANC screenings Days -30 to -1	2.8	1.5

Table 1ab. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	9.8	9.1
Mean number of emergency room encounters	1.1	1.4
Mean number of inpatient hospital encounters	1.1	1.4
Mean number of non-acute institutional encounters	0.5	0.8
Mean number of other ambulatory encounters	6.5	5.9
Mean number of filled prescriptions	24.5	15.3
Mean number of generics dispensed	9.3	6.1
Mean number of unique drug classes dispensed	8.6	5.7

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1ac. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	Percent
Unique patients	22	
Episodes	22	100.0%
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	33.9	12.6
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	15	68.2%
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	11	50.0%
Male	11	50.0%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	10	45.5%
White	7	31.8%
Hispanic origin		
Yes	*****	*****
No	13	59.1%
Unknown	*****	*****
Year		
2010	*****	*****
2011	0	0.0%
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	0	0.0%
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1ac. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index		
Anxiety	12	54.5%
Bipolar Disorder	11	50.0%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	7	31.8%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	17	77.3%
Substance Use Disorder	8	36.4%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	14	63.6%
ANC Screening Days -14 to -1	19	86.4%
ANC Screening Days -30 to -1	22	100.0%
Mean number of ANC screenings Days -7 to -1	0.7	0.7
Mean number of ANC screenings Days -14 to -1	1.3	0.8
Mean number of ANC screenings Days -30 to -1	2.7	1.4

Table 1ac. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	9.4	8.6
Mean number of emergency room encounters	1.0	1.3
Mean number of inpatient hospital encounters	1.4	1.3
Mean number of non-acute institutional encounters	0.4	0.7
Mean number of other ambulatory encounters	6.3	5.6
Mean number of filled prescriptions	23.2	14.4
Mean number of generics dispensed	8.8	5.8
Mean number of unique drug classes dispensed	8.1	5.4

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1ad. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1], from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	1,053	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	42.5	16.0
Age	**Number**	**Percent**
12-18 years	43	4.1%
19-35 years	386	36.7%
36-50 years	270	25.6%
51-64 years	245	23.3%
65-75 years	68	6.5%
≥ 75 years	41	3.9%
Sex		
Female	452	42.9%
Male	601	57.1%
Race[3]		
American Indian or Alaska Native	*****	*****
Asian	29	2.8%
Black or African American	87	8.3%
Multi-racial	11	1.0%
Native Hawaiian or Other Pacific Islander	*****	*****
Unknown	292	27.7%
White	626	59.4%
Hispanic origin		
Yes	50	4.7%
No	770	73.1%
Unknown	233	22.1%
Year		
2010	28	2.7%
2011	40	3.8%
2012	58	5.5%
2013	47	4.5%
2014	60	5.7%
2015	65	6.2%
2016	82	7.8%
2017	72	6.8%
2018	81	7.7%
2019	97	9.2%
2020	103	9.8%
2021	106	10.1%
2022	113	10.7%
2023	101	9.6%
2024	0	0.0%

Table 1ad. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1], from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	491	46.6%
Bipolar Disorder	439	41.7%
Cardiovascular Disorder	78	7.4%
Chronic Kidney Disease	66	6.3%
Chronic Obstructive Pulmonary Disorder	85	8.1%
Depressive Disorder	438	41.6%
Diabetes	172	16.3%
Post-Traumatic Stress Disorder	107	10.2%
Schizophrenia or Schizoaffective Disorder	836	79.4%
Substance Use Disorder	276	26.2%
Crohn's Disease	*****	*****
Rheumatoid Arthritis	46	4.4%
Chronic Autoimmune Hepatitis	12	1.1%
Systematic Lupus Erythematosus	0	0.0%
Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	**Mean**	**Standard Deviation**
Mean number of ambulatory encounters	13.3	13.3
Mean number of emergency room encounters	1.2	2.2
Mean number of inpatient hospital encounters	0.8	1.5
Mean number of non-acute institutional encounters	0.4	1.0
Mean number of other ambulatory encounters	7.3	9.7
Mean number of filled prescriptions	25.9	23.4
Mean number of generics dispensed	8.7	6.3
Mean number of unique drug classes dispensed	8.0	5.7

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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Table 1ae. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	30	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	37.8	13.5
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	17	56.7%
36-50 years	*****	*****
51-64 years	7	23.3%
65-75 years	*****	*****
≥ 75 years	*****	*****
Sex		
Female	14	46.7%
Male	16	53.3%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	12	40.0%
White	13	43.3%
Hispanic origin		
Yes	*****	*****
No	19	63.3%
Unknown	*****	*****
Year		
2010	*****	*****
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	*****	*****
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1ae. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	16	53.3%
Bipolar Disorder	15	50.0%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	9	30.0%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	24	80.0%
Substance Use Disorder	10	33.3%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	7	23.3%
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	18	60.0%
ANC Screening Days -14 to -1	24	80.0%
ANC Screening Days -30 to -1	27	90.0%
Mean number of ANC screenings Days -7 to -1	0.7	0.7
Mean number of ANC screenings Days -14 to -1	1.2	0.8
Mean number of ANC screenings Days -30 to -1	2.5	1.6

Table 1ae. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	10.3	8.2
Mean number of emergency room encounters	0.9	1.2
Mean number of inpatient hospital encounters	1.0	1.1
Mean number of non-acute institutional encounters	0.5	0.8
Mean number of other ambulatory encounters	6.3	5.6
Mean number of filled prescriptions	24.9	18.6
Mean number of generics dispensed	9.0	6.4
Mean number of unique drug classes dispensed	8.2	5.8

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1af. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	6	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	53.0	11.4
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	0	0.0%
≥ 75 years	*****	*****
Sex		
Female	*****	*****
Male	*****	*****
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	*****	*****
White	*****	*****
Hispanic origin		
Yes	0	0.0%
No	6	100.0%
Unknown	0	0.0%
Year		
2010	0	0.0%
2011	*****	*****
2012	0	0.0%
2013	0	0.0%
2014	0	0.0%
2015	0	0.0%
2016	0	0.0%
2017	*****	*****
2018	*****	*****
2019	*****	*****
2020	0	0.0%
2021	0	0.0%
2022	*****	*****
2023	0	0.0%
2024	0	0.0%

Table 1af. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	*****	*****
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	*****	*****
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	6	100.0%
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	*****	*****
Mean number of ANC screenings Days -7 to -1	0.5	0.4
Mean number of ANC screenings Days -14 to -1	1.0	0.4
Mean number of ANC screenings Days -30 to -1	1.8	1.1

Table 1af. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	13.8	5.8
Mean number of emergency room encounters	0.7	0.7
Mean number of inpatient hospital encounters	0.2	0.0
Mean number of non-acute institutional encounters	0.7	0.6
Mean number of other ambulatory encounters	8.3	5.5
Mean number of filled prescriptions	39.3	18.4
Mean number of generics dispensed	12.3	4.2
Mean number of unique drug classes dispensed	11.2	3.7

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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

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Table 1ag. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	*****	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	30.1	0.0
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	0	0.0%
65-75 years	0	0.0%
≥ 75 years	0	0.0%
Sex		
Female	0	0.0%
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	*****	*****
White	0	0.0%
Hispanic origin		
Yes	*****	*****
No	*****	*****
Unknown	*****	*****
Year		
2010	0	0.0%
2011	0	0.0%
2012	0	0.0%
2013	*****	*****
2014	0	0.0%
2015	*****	*****
2016	*****	*****
2017	0	0.0%
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	*****	*****
2022	0	0.0%
2023	0	0.0%
2024	0	0.0%

Table 1ag. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	0	0.0%
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	0	0.0%
Depressive Disorder	0	0.0%
Diabetes	0	0.0%
Post-Traumatic Stress Disorder	0	0.0%
Schizophrenia or Schizoaffective Disorder	*****	*****
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	0	0.0%
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	0	0.0%
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	*****	*****
Mean number of ANC screenings Days -7 to -1	0.8	0.0
Mean number of ANC screenings Days -14 to -1	1.5	0.0
Mean number of ANC screenings Days -30 to -1	2.5	0.0

Table 1ag. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate but not Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	7.8	0.0
Mean number of emergency room encounters	0.8	0.0
Mean number of inpatient hospital encounters	2.3	0.0
Mean number of non-acute institutional encounters	0.8	0.0
Mean number of other ambulatory encounters	2.5	0.0
Mean number of filled prescriptions	5.5	0.0
Mean number of generics dispensed	2.3	0.0
Mean number of unique drug classes dispensed	2.3	0.0

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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Table 1ah. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	6	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	39.8	13.8
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	*****	*****
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	0	0.0%
≥ 75 years	0	0.0%
Sex		
Female	*****	*****
Male	*****	*****
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	*****	*****
White	*****	*****
Hispanic origin		
Yes	*****	*****
No	*****	*****
Unknown	*****	*****
Year		
2010	0	0.0%
2011	*****	*****
2012	0	0.0%
2013	*****	*****
2014	0	0.0%
2015	*****	*****
2016	*****	*****
2017	0	0.0%
2018	0	0.0%
2019	0	0.0%
2020	0	0.0%
2021	*****	*****
2022	*****	*****
2023	0	0.0%
2024	0	0.0%

Table 1ah. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	*****	*****
Bipolar Disorder	*****	*****
Cardiovascular Disorder	0	0.0%
Chronic Kidney Disease	*****	*****
Chronic Obstructive Pulmonary Disorder	0	0.0%
Depressive Disorder	*****	*****
Diabetes	*****	*****
Post-Traumatic Stress Disorder	0	0.0%
Schizophrenia or Schizoaffective Disorder	*****	*****
Substance Use Disorder	*****	*****
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	0	0.0%
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	*****	*****
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	*****	*****
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	*****	*****
ANC Screening Days -14 to -1	*****	*****
ANC Screening Days -30 to -1	*****	*****
Mean number of ANC screenings Days -7 to -1	1.8	2.1
Mean number of ANC screenings Days -14 to -1	3.7	4.2
Mean number of ANC screenings Days -30 to -1	6.2	7.1

Table 1ah. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Moderate Regardless of Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	10.7	2.0
Mean number of emergency room encounters	1.0	0.4
Mean number of inpatient hospital encounters	1.7	0.0
Mean number of non-acute institutional encounters	0.7	0.7
Mean number of other ambulatory encounters	6.0	5.7
Mean number of filled prescriptions	22.3	30.2
Mean number of generics dispensed	8.2	9.1
Mean number of unique drug classes dispensed	7.2	7.6

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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Table 1ai. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	20	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	34.7	13.3
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	13	65.0%
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	11	55.0%
Male	9	45.0%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	9	45.0%
White	7	35.0%
Hispanic origin		
Yes	*****	*****
No	12	60.0%
Unknown	*****	*****
Year		
2010	*****	*****
2011	0	0.0%
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	0	0.0%
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1ai. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	12	60.0%
Bipolar Disorder	10	50.0%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	7	35.0%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	15	75.0%
Substance Use Disorder	7	35.0%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	12	60.0%
ANC Screening Days -14 to -1	17	85.0%
ANC Screening Days -30 to -1	20	100.0%
Mean number of ANC screenings Days -7 to -1	0.7	0.8
Mean number of ANC screenings Days -14 to -1	1.4	0.8
Mean number of ANC screenings Days -30 to -1	2.8	1.5

Table 1ai. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild but not Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	9.8	9.1
Mean number of emergency room encounters	1.1	1.4
Mean number of inpatient hospital encounters	1.1	1.4
Mean number of non-acute institutional encounters	0.5	0.8
Mean number of other ambulatory encounters	6.5	5.9
Mean number of filled prescriptions	24.5	15.3
Mean number of generics dispensed	9.3	6.1
Mean number of unique drug classes dispensed	8.6	5.7

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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Table 1aj. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Patient Characteristics[2]	Number	
Unique patients	22	
Demographic Characteristics	**Mean**	**Standard Deviation**
Age (years)	33.9	12.6
Age	**Number**	**Percent**
12-18 years	0	0.0%
19-35 years	15	68.2%
36-50 years	*****	*****
51-64 years	*****	*****
65-75 years	*****	*****
≥ 75 years	0	0.0%
Sex		
Female	11	50.0%
Male	11	50.0%
Race[3]		
American Indian or Alaska Native	0	0.0%
Asian	*****	*****
Black or African American	*****	*****
Multi-racial	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
Unknown	10	45.5%
White	7	31.8%
Hispanic origin		
Yes	*****	*****
No	13	59.1%
Unknown	*****	*****
Year		
2010	*****	*****
2011	0	0.0%
2012	0	0.0%
2013	*****	*****
2014	*****	*****
2015	*****	*****
2016	*****	*****
2017	*****	*****
2018	*****	*****
2019	0	0.0%
2020	*****	*****
2021	*****	*****
2022	*****	*****
2023	*****	*****
2024	0	0.0%

Table 1aj. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Characteristics [-183, -1] Prior to Clozapine Index	Number	Percent
Anxiety	12	54.5%
Bipolar Disorder	11	50.0%
Cardiovascular Disorder	*****	*****
Chronic Kidney Disease	0	0.0%
Chronic Obstructive Pulmonary Disorder	*****	*****
Depressive Disorder	7	31.8%
Diabetes	*****	*****
Post-Traumatic Stress Disorder	*****	*****
Schizophrenia or Schizoaffective Disorder	17	77.3%
Substance Use Disorder	8	36.4%
Crohn's Disease	0	0.0%
Rheumatoid Arthritis	*****	*****
Chronic Autoimmune Hepatitis	0	0.0%
Systematic Lupus Erythematosus	0	0.0%
Health Characteristics [-30, -1] Days Prior to Neutropenic Event		
Chemotherapy	0	0.0%
Inpatient Serious Infection	0	0.0%
Health Characteristics [0, 30] Days After Neutropenic Event		
Inpatient Serious Infection	0	0.0%
Antimicrobials	*****	*****
Filgrastim Injections	0	0.0%
Absolute Neutrophil Count (ANC) Screenings Prior to Defining Neutropenic Event	**Number/Mean**	**Percent/Standard Deviation[4]**
ANC Screening Days -7 to -1	14	63.6%
ANC Screening Days -14 to -1	19	86.4%
ANC Screening Days -30 to -1	22	100.0%
Mean number of ANC screenings Days -7 to -1	0.7	0.7
Mean number of ANC screenings Days -14 to -1	1.3	0.8
Mean number of ANC screenings Days -30 to -1	2.7	1.4

Table 1aj. Aggregated Characteristics of Patients with 183-Day Clozapine Washout, Cohort Re-entry not Allowed, with Complete Correspondence[1] and Evidence of Mild Regardless of Moderate or Severe Neutropenia, from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

Health Service Utilization Intensity Metrics [-183,-1] Days Prior to Clozapine Index	Mean	Standard Deviation
Mean number of ambulatory encounters	9.4	8.6
Mean number of emergency room encounters	1.0	1.3
Mean number of inpatient hospital encounters	1.4	1.3
Mean number of non-acute institutional encounters	0.4	0.7
Mean number of other ambulatory encounters	6.3	5.6
Mean number of filled prescriptions	23.2	14.4
Mean number of generics dispensed	8.8	5.8
Mean number of unique drug classes dispensed	8.1	5.4

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]All metrics are based on total number of episodes per group, except for sex, race, and Hispanic origin which are based on total number of unique patients.

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

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Table 2a. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Any Neutropenia with Complete Correspondence[1]					
30-Day Clozapine Washout Cohort Re-entry Allowed	1,595	2,223	53	749.8	273,851
30-Day Clozapine Washout Cohort Re-entry not Allowed	1,595	1,595	43	548.9	200,469
183-Day Clozapine Washout Cohort Re-entry Allowed	1,053	1,087	33	366.0	133,674
183-Day Clozapine Washout Cohort Re-entry not Allowed	1,053	1,053	30	354.9	129,628
Severe Neutropenia (Lab Result or Diagnosis) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed	1,595	2,223	15	756.5	276,328
30-Day Clozapine Washout Cohort Re-entry not Allowed	1,595	1,595	11	554.7	202,617
183-Day Clozapine Washout Cohort Re-entry Allowed	1,053	1,087	8	370.2	135,209
183-Day Clozapine Washout Cohort Re-entry not Allowed	1,053	1,053	6	359.0	131,118
Severe Neutropenia (Lab Result Regardless of Diagnosis) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed	1,595	2,223	6	759.4	277,354
30-Day Clozapine Washout Cohort Re-entry not Allowed	1,595	1,595	*****	556.8	203,358
183-Day Clozapine Washout Cohort Re-entry Allowed	1,053	1,087	*****	371.0	135,490
183-Day Clozapine Washout Cohort Re-entry not Allowed	1,053	1,053	*****	359.4	131,267
Severe Neutropenia (Diagnosis Regardless of Lab Result) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed	1,595	2,223	10	757.4	276,648
30-Day Clozapine Washout Cohort Re-entry not Allowed	1,595	1,595	8	555.4	202,861
183-Day Clozapine Washout Cohort Re-entry Allowed	1,053	1,087	*****	371.0	135,522
183-Day Clozapine Washout Cohort Re-entry not Allowed	1,053	1,053	*****	359.6	131,362
Moderate but not Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed	1,595	2,223	6	759.4	277,369
30-Day Clozapine Washout Cohort Re-entry not Allowed	1,595	1,595	*****	556.8	203,360
183-Day Clozapine Washout Cohort Re-entry Allowed	1,053	1,087	*****	371.0	135,516
183-Day Clozapine Washout Cohort Re-entry not Allowed	1,053	1,053	*****	359.4	131,269
Moderate Regardless of Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed	1,595	2,223	8	759.3	277,326
30-Day Clozapine Washout Cohort Re-entry not Allowed	1,595	1,595	6	556.7	203,317
183-Day Clozapine Washout Cohort Re-entry Allowed	1,053	1,087	7	370.9	135,473
183-Day Clozapine Washout Cohort Re-entry not Allowed	1,053	1,053	6	359.3	131,226

Table 2a. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Mild but not Moderate or Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed	1,595	2,223	32	754.5	275,589
30-Day Clozapine Washout Cohort Re-entry not Allowed	1,595	1,595	28	552.5	201,783
183-Day Clozapine Washout Cohort Re-entry Allowed	1,053	1,087	20	368.6	134,642
183-Day Clozapine Washout Cohort Re-entry not Allowed	1,053	1,053	20	356.9	130,350
Mild Regardless of Moderate or Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed	1,595	2,223	34	754.2	275,485
30-Day Clozapine Washout Cohort Re-entry not Allowed	1,595	1,595	30	552.2	201,679
183-Day Clozapine Washout Cohort Re-entry Allowed	1,053	1,087	22	368.3	134,538
183-Day Clozapine Washout Cohort Re-entry not Allowed	1,053	1,053	22	356.6	130,246

Table 2a. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024 (Continued)

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Any Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed	0.07 (0.05, 0.09)	220,356	603,797
30-Day Clozapine Washout Cohort Re-entry not Allowed	0.08 (0.06, 0.11)	166,890	443,897
183-Day Clozapine Washout Cohort Re-entry Allowed	0.09 (0.06, 0.13)	113,939	277,927
183-Day Clozapine Washout Cohort Re-entry not Allowed	0.08 (0.06, 0.12)	110,732	267,686
Severe Neutropenia (Lab Result or Diagnosis) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed	0.02 (0.01, 0.03)	222,227	608,574
30-Day Clozapine Washout Cohort Re-entry not Allowed	0.02 (0.01, 0.04)	168,546	448,084
183-Day Clozapine Washout Cohort Re-entry Allowed	0.02 (0.01, 0.04)	115,161	280,679
183-Day Clozapine Washout Cohort Re-entry not Allowed	0.02 (0.01, 0.04)	111,909	270,287
Severe Neutropenia (Lab Result Regardless of Diagnosis) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed	0.01 (0.00, 0.02)	223,156	610,646
30-Day Clozapine Washout Cohort Re-entry not Allowed	0.01 (0.00, 0.02)	169,190	449,587
183-Day Clozapine Washout Cohort Re-entry Allowed	0.01 (0.01, 0.03)	115,382	281,135
183-Day Clozapine Washout Cohort Re-entry not Allowed	0.01 (0.00, 0.03)	111,998	270,480
Severe Neutropenia (Diagnosis Regardless of Lab Result) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed	0.01 (0.01, 0.02)	222,475	609,253
30-Day Clozapine Washout Cohort Re-entry not Allowed	0.01 (0.01, 0.03)	168,718	448,649
183-Day Clozapine Washout Cohort Re-entry Allowed	0.01 (0.00, 0.03)	115,402	281,347
183-Day Clozapine Washout Cohort Re-entry not Allowed	0.01 (0.00, 0.03)	112,081	270,852
Moderate but not Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed	0.01 (0.00, 0.02)	223,160	610,599
30-Day Clozapine Washout Cohort Re-entry not Allowed	0.01 (0.00, 0.02)	169,163	449,577
183-Day Clozapine Washout Cohort Re-entry Allowed	0.01 (0.01, 0.03)	115,379	281,078
183-Day Clozapine Washout Cohort Re-entry not Allowed	0.01 (0.00, 0.03)	111,971	270,470
Moderate Regardless of Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed	0.01 (0.01, 0.02)	223,157	610,596
30-Day Clozapine Washout Cohort Re-entry not Allowed	0.01 (0.00, 0.02)	169,160	449,574
183-Day Clozapine Washout Cohort Re-entry Allowed	0.02 (0.01, 0.04)	115,376	281,075
183-Day Clozapine Washout Cohort Re-entry not Allowed	0.02 (0.01, 0.04)	111,968	270,467

Table 2a. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024 (Continued)

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Mild but not Moderate or Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed	0.04 (0.03, 0.06)	221,803	607,313
30-Day Clozapine Washout Cohort Re-entry not Allowed	0.05 (0.03, 0.07)	167,931	446,578
183-Day Clozapine Washout Cohort Re-entry Allowed	0.05 (0.04, 0.08)	114,671	279,815
183-Day Clozapine Washout Cohort Re-entry not Allowed	0.06 (0.04, 0.09)	111,218	269,056
Mild Regardless of Moderate or Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed	0.05 (0.03, 0.06)	221,759	607,269
30-Day Clozapine Washout Cohort Re-entry not Allowed	0.05 (0.04, 0.08)	167,887	446,534
183-Day Clozapine Washout Cohort Re-entry Allowed	0.06 (0.04, 0.09)	114,627	279,771
183-Day Clozapine Washout Cohort Re-entry not Allowed	0.06 (0.04, 0.09)	111,174	269,012

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

*****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.

Table 2b. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -7 to -1

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Any Neutropenia with Complete Correspondence[1]					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	23	23	23	3.7	1,338
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	21	21	21	3.4	1,230
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	19	19	19	3.2	1,172
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	18	18	18	2.9	1,075
Severe Neutropenia (Lab Result or Diagnosis) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.6	219
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.3	122
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.6	219
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.3	122
Severe Neutropenia (Lab Result Regardless of Diagnosis) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.6	201
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.3	104
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.6	201
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.3	104

Table 2b. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -7 to -1

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Severe Neutropenia (Diagnosis Regardless of Lab Result) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.2	72
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.2	72
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.2	72
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.2	72
Moderate but not Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.3	121
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.3	121
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.3	121
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.3	121
Moderate Regardless of Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.7	244
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.7	244
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.7	244
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	*****	*****	*****	0.7	244

Table 2b. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -7 to -1

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Mild but not Moderate or Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	16	16	16	2.8	1,019
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	15	15	15	2.8	1,008
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	12	12	12	2.3	853
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	12	12	12	2.3	853
Mild Regardless of Moderate or Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	18	18	18	3.0	1,113
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	17	17	17	3.0	1,102
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -7 to -1	14	14	14	2.6	947
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -7 to -1	14	14	14	2.6	947

Table 2b. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -7 to -1 (Continued)

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Any Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	6.28 (4.17, 9.45)	1,266	3,023
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	6.24 (4.07, 9.56)	1,179	2,815
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	5.92 (3.78, 9.28)	1,104	2,396
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	6.12 (3.85, 9.71)	1,029	2,235
Severe Neutropenia (Lab Result or Diagnosis) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	6.67 (2.50, 17.78)	196	397
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	8.98 (2.90, 27.85)	121	237
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	6.67 (2.50, 17.78)	196	397
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	8.98 (2.90, 27.85)	121	237
Severe Neutropenia (Lab Result Regardless of Diagnosis) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	5.45 (1.76, 16.90)	177	373
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	7.02 (1.76, 28.09)	102	212
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	5.45 (1.76, 16.90)	177	373
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	7.02 (1.76, 28.09)	102	212

Table 2b. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -7 to -1 (Continued)

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Severe Neutropenia (Diagnosis Regardless of Lab Result) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	10.15 (2.54, 40.57)	72	188
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	10.15 (2.54, 40.57)	72	188
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	10.15 (2.54, 40.57)	72	188
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	10.15 (2.54, 40.57)	72	188
Moderate but not Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	9.06 (2.92, 28.08)	124	174
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	9.06 (2.92, 28.08)	124	174
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	9.06 (2.92, 28.08)	124	174
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	9.06 (2.92, 28.08)	124	174
Moderate Regardless of Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	7.48 (3.12, 17.98)	226	392
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	7.48 (3.12, 17.98)	226	392
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	7.48 (3.12, 17.98)	226	392
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	7.48 (3.12, 17.98)	226	392

Table 2b. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -7 to -1 (Continued)

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Mild but not Moderate or Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	5.74 (3.51, 9.36)	966	2,472
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	5.44 (3.28, 9.02)	954	2,424
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	5.14 (2.92, 9.05)	804	1,845
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	5.14 (2.92, 9.05)	804	1,845
Mild Regardless of Moderate or Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	5.91 (3.72, 9.38)	1,062	2,596
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	5.63 (3.50, 9.06)	1,050	2,548
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -7 to -1	5.40 (3.20, 9.12)	900	1,969
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -7 to -1	5.40 (3.20, 9.12)	900	1,969

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

*****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.

Table 2c. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -14 to -1

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Any Neutropenia with Complete Correspondence[1]					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	30	30	30	5.1	1,880
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	28	28	28	4.9	1,772
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	25	25	25	4.7	1,701
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	24	24	24	4.4	1,604
Severe Neutropenia (Lab Result or Diagnosis) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.6	230
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.4	133
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.6	230
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.4	133
Severe Neutropenia (Lab Result Regardless of Diagnosis) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.6	201
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.3	104
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.6	201
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.3	104

Table 2c. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -14 to -1

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Severe Neutropenia (Diagnosis Regardless of Lab Result) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.2	83
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.2	83
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.2	83
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.2	83
Moderate but not Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.3	121
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.3	121
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.3	121
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.3	121
Moderate Regardless of Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.7	244
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.7	244
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.7	244
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	*****	*****	*****	0.7	244

Table 2c. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -14 to -1

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Mild but not Moderate or Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	22	22	22	4.2	1,550
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	21	21	21	4.2	1,539
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	17	17	17	3.8	1,371
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	17	17	17	3.8	1,371
Mild Regardless of Moderate or Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	24	24	24	4.5	1,644
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	23	23	23	4.5	1,633
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -14 to -1	19	19	19	4.0	1,465
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -14 to -1	19	19	19	4.0	1,465

Table 2c. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -14 to -1 (Continued)

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Any Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	5.83 (4.08, 8.34)	1,815	4,958
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	5.77 (3.98, 8.36)	1,728	4,750
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	5.37 (3.63, 7.94)	1,639	4,275
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	5.47 (3.66, 8.15)	1,564	4,114
Severe Neutropenia (Lab Result or Diagnosis) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	7.94 (3.30, 19.08)	208	409
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	10.98 (4.12, 29.27)	133	249
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	7.94 (3.30, 19.08)	208	409
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	10.98 (4.12, 29.27)	133	249
Severe Neutropenia (Lab Result Regardless of Diagnosis) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	5.45 (1.76, 16.90)	177	373
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	7.02 (1.76, 28.09)	102	212
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	5.45 (1.76, 16.90)	177	373
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	7.02 (1.76, 28.09)	102	212

Table 2c. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -14 to -1 (Continued)

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Severe Neutropenia (Diagnosis Regardless of Lab Result) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	13.20 (4.26, 40.93)	84	200
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	13.20 (4.26, 40.93)	84	200
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	13.20 (4.26, 40.93)	84	200
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	13.20 (4.26, 40.93)	84	200
Moderate but not Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	9.06 (2.92, 28.08)	124	174
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	9.06 (2.92, 28.08)	124	174
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	9.06 (2.92, 28.08)	124	174
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	9.06 (2.92, 28.08)	124	174
Moderate Regardless of Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	7.48 (3.12, 17.98)	226	392
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	7.48 (3.12, 17.98)	226	392
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	7.48 (3.12, 17.98)	226	392
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	7.48 (3.12, 17.98)	226	392

Table 2c. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -14 to -1 (Continued)

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Mild but not Moderate or Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	5.18 (3.41, 7.87)	1,503	4,395
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	4.98 (3.25, 7.64)	1,491	4,347
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	4.53 (2.82, 7.29)	1,327	3,711
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	4.53 (2.82, 7.29)	1,327	3,711
Mild Regardless of Moderate or Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	5.33 (3.57, 7.96)	1,599	4,519
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	5.14 (3.42, 7.74)	1,587	4,471
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -14 to -1	4.74 (3.02, 7.43)	1,423	3,835
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -14 to -1	4.74 (3.02, 7.43)	1,423	3,835

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

*****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.

Table 2d. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -30 to -1

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Any Neutropenia with Complete Correspondence[1]					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	41	43	43	7.1	2,592
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	39	39	39	6.6	2,426
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	28	29	29	5.3	1,930
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	27	27	27	4.9	1,783
Severe Neutropenia (Lab Result or Diagnosis) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	10	11	11	1.4	500
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	9	9	9	1.0	353
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	*****	6	6	0.8	280
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.4	133
Severe Neutropenia (Lab Result Regardless of Diagnosis) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.6	201
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.3	104
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.6	201
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.3	104

Table 2d. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -30 to -1

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Severe Neutropenia (Diagnosis Regardless of Lab Result) with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	8	9	9	1.0	353
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	8	8	8	0.8	303
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.4	133
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.2	83
Moderate but not Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.3	121
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.3	121
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.3	121
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.3	121
Moderate Regardless of Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.7	244
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.7	244
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.7	244
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	*****	*****	*****	0.7	244

Table 2d. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -30 to -1

	Number of Patients	Number of Exposure Episodes	Number of Exposure Episodes with an Event	Total Years at Risk	Total Days at Risk
Mild but not Moderate or Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	28	29	29	5.5	1,992
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	27	27	27	5.4	1,973
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	20	20	20	4.2	1,550
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	20	20	20	4.2	1,550
Mild Regardless of Moderate or Severe Neutropenia with Complete Correspondence					
30-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	30	31	31	5.7	2,086
30-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	29	29	29	5.7	2,067
183-Day Clozapine Washout Cohort Re-entry Allowed					
Evidence of ANC Screening Days -30 to -1	22	22	22	4.5	1,644
183-Day Clozapine Washout Cohort Re-entry not Allowed					
Evidence of ANC Screening Days -30 to -1	22	22	22	4.5	1,644

Table 2d. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -30 to -1

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Any Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	6.06 (4.49, 8.17)	2,517	6,582
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	5.87 (4.29, 8.04)	2,372	6,244
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	5.49 (3.81, 7.90)	1,859	4,643
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	5.53 (3.79, 8.07)	1,733	4,380
Severe Neutropenia (Lab Result or Diagnosis) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	8.04 (4.45, 14.51)	484	1,179
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	9.31 (4.85, 17.90)	358	917
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	7.83 (3.52, 17.42)	259	511
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	10.98 (4.12, 29.27)	133	249
Severe Neutropenia (Lab Result Regardless of Diagnosis) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	5.45 (1.76, 16.90)	177	373
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	7.02 (1.76, 28.09)	102	212
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	5.45 (1.76, 16.90)	177	373
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	7.02 (1.76, 28.09)	102	212

Table 2d. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -30 to -1

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Severe Neutropenia (Diagnosis Regardless of Lab Result) with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	9.31 (4.85, 17.90)	360	970
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	9.64 (4.82, 19.28)	309	868
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	10.98 (4.12, 29.27)	135	302
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	13.20 (4.26, 40.93)	84	200
Moderate but not Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	9.06 (2.92, 28.08)	124	174
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	9.06 (2.92, 28.08)	124	174
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	9.06 (2.92, 28.08)	124	174
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	9.06 (2.92, 28.08)	124	174
Moderate Regardless of Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	7.48 (3.12, 17.98)	226	392
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	7.48 (3.12, 17.98)	226	392
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	7.48 (3.12, 17.98)	226	392
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	7.48 (3.12, 17.98)	226	392

Table 2d. Summary of Exposures of Interest from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024, by ANC Screening Days -30 to -1

	Event Rate per Patient-Year at Risk (95% Confidence Interval)	Total Days Supply During Exposure Episodes	Total Amount Supplied During Exposure Episodes
Mild but not Moderate or Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	5.32 (3.70, 7.65)	1,929	5,249
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	5.00 (3.43, 7.29)	1,910	5,173
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	4.71 (3.04, 7.31)	1,496	3,977
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	4.71 (3.04, 7.31)	1,496	3,977
Mild Regardless of Moderate or Severe Neutropenia with Complete Correspondence			
30-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	5.43 (3.82, 7.72)	2,025	5,373
30-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	5.12 (3.56, 7.37)	2,006	5,297
183-Day Clozapine Washout Cohort Re-entry Allowed			
Evidence of ANC Screening Days -30 to -1	4.89 (3.22, 7.42)	1,592	4,101
183-Day Clozapine Washout Cohort Re-entry not Allowed			
Evidence of ANC Screening Days -30 to -1	4.89 (3.22, 7.42)	1,592	4,101

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

*****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.

Table 3a. Summary of Episode-Level[1] Cohort Attrition in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

	Clozapine Episodes (30 Day Washout)		Clozapine Episodes (183 Day Washout)	
	Remaining	**Excluded**	**Remaining**	**Excluded**
Members meeting enrollment and demographic requirements				
Enrolled at any point during the query period	478,254,735	N/A[2]	478,254,735	N/A
Had required coverage type (medical and/or drug coverage)	355,917,592	122,337,143	355,917,592	122,337,143
Enrolled during specified age range	314,638,189	41,279,403	314,638,189	41,279,403
Met demographic requirements (sex, race, and Hispanic origin)	314,504,744	133,445	314,504,744	133,445
Members with a valid index event				
Had any cohort-defining claim during the query period	202,044	314,302,700	202,044	314,302,700
Cohort episodes with a valid index date				
Total number of claims with cohort-identifying codes during the query period	11,328,740	N/A	11,328,740	N/A
Claim recorded during specified age range	11,322,855	5,885	11,322,855	5,885
Episode defining index claim recorded during the query period	310,477	11,012,378	229,901	11,092,954
Cohort episodes with required pre-index history				
Had sufficient pre-index continuous enrollment	164,971	145,506	93,118	136,783
Final cohort				
Number of members	105,067	N/A	84,208	N/A
Number of episodes	164,971	N/A	93,118	N/A

*All 13 Data Partners contributed to these cohorts.

[1]Cohorts are formed by first evaluating enrollment and demographic requirements as well as index events among members, then evaluating index dates, pre-index history, and post-index follow-up among episodes. Because of this, the number remaining often increases from the member- to episode-level steps.

[2]N/A: Not Applicable

Table 3b. Summary of Patient-Level Cohort Attrition in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

	Patients with Clozapine Episode (30 Day Washout)		Patients with Clozapine Episode (183 Day Washout)	
	Remaining	**Excluded**	**Remaining**	**Excluded**
Members meeting enrollment and demographic requirements				
Enrolled at any point during the query period	478,254,735	N/A[1]	478,254,735	N/A
Had required coverage type (medical and/or drug coverage)	355,917,592	122,337,143	355,917,592	122,337,143
Enrolled during specified age range	314,638,189	41,279,403	314,638,189	41,279,403
Met demographic requirements (sex, race, and Hispanic origin)	314,504,744	133,445	314,504,744	133,445
Members with a valid index event				
Had any cohort-defining claim during the query period	202,044	314,302,700	202,044	314,302,700
Claim recorded during specified age range	201,948	96	201,948	96
Episode defining index claim recorded during the query period	200,754	1,194	200,336	1,612
Members with required pre-index history				
Had sufficient pre-index continuous enrollment	105,067	95,687	84,208	116,128
Final cohort				
Number of members	105,067	N/A	84,208	N/A
Number of episodes	105,067	N/A	84,208	N/A

*All 13 Data Partners contributed to these cohorts.

[1]N/A: Not Applicable

Table 3c. Summary of Episode Level[1] Cohort Attrition from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

	Clozapine Regardless of Neutropenia				Clozapine Regardless of Neutropenia with Complete Correspondence[2]			
	30-Day Clozapine Washout Cohort Re-entry Allowed		183-Day Clozapine Washout Cohort Re-entry Allowed		30-Day Clozapine Washout Cohort Re-entry Allowed		183-Day Clozapine Washout Cohort Re-entry Allowed	
	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded
Members meeting enrollment and demographic requirements								
Enrolled at any point during the query period	118,473,915	N/A[3]	118,473,915	N/A	118,473,915	N/A	118,473,915	N/A
Had required coverage type (medical and/or drug coverage)	87,408,345	31,065,570	87,408,345	31,065,570	87,408,345	31,065,570	87,408,345	31,065,570
Enrolled during specified age range	81,791,681	5,616,664	81,791,681	5,616,664	81,791,681	5,616,664	81,791,681	5,616,664
Met demographic requirements (sex, race, and Hispanic origin)	81,769,896	21,785	81,769,896	21,785	81,769,896	21,785	81,769,896	21,785
Members with a valid index event								
Had any cohort-defining claim during the query period	15,198	81,754,698	15,198	81,754,698	15,198	81,754,698	15,198	81,754,698
Cohort episodes with a valid index date								
Total number of claims with cohort-identifying codes during the query period	460,359	N/A	460,359	N/A	460,359	N/A	460,359	N/A
Claim recorded during specified age range	460,024	335	460,024	335	460,024	335	460,024	335
Episode defining index claim recorded during the query period	21,162	438,862	15,598	444,426	21,162	438,862	15,598	444,426
Cohort episodes with required pre-index history								
Had sufficient pre-index continuous enrollment	10,473	10,689	5,647	9,951	10,473	10,689	5,647	9,951
Met inclusion and exclusion criteria[4]	10,473	0	5,647	0	2,223	8,250	1,087	4,560
No evidence of Complete Correspondence	N/A	N/A	N/A	N/A	N/A	8,250	N/A	4,560

Table 3c. Summary of Episode Level[1] Cohort Attrition from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

	Clozapine Regardless of Neutropenia				Clozapine Regardless of Neutropenia with Complete Correspondence[2]			
	30-Day Clozapine Washout Cohort Re-entry Allowed		183-Day Clozapine Washout Cohort Re-entry Allowed		30-Day Clozapine Washout Cohort Re-entry Allowed		183-Day Clozapine Washout Cohort Re-entry Allowed	
	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded
Final cohort								
Number of members	6,698	N/A	5,306	N/A	1,595	N/A	1,053	N/A
Number of episodes	10,473	N/A	5,647	N/A	2,223	N/A	1,087	N/A

[1]Cohorts are formed by first evaluating enrollment and demographic requirements as well as index events among members, then evaluating index dates, pre-index history, and post-index follow-up among episodes. Because of this, the number remaining often increases from the member- to episode-level steps.

[2]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[3]N/A: Not Applicable

[4]Episodes can meet multiple inclusion and/or exclusion criteria; therefore, the total number of episodes excluded overall may not equal the sum of all episodes in each criterion.

Table 3d. Summary of Patient Level Cohort Attrition from Data Partners with Absolute Neutrophil Count (ANC) Laboratory Results in the Sentinel Distributed Database (SDD) from January 1, 2010 to January 31, 2024

	Clozapine Regardless of Neutropenia				Clozapine Regardless of Neutropenia with Complete Correspondence[1]			
	30-Day Clozapine Washout Cohort Re-entry not Allowed		183-Day Clozapine Washout Cohort Re-entry not Allowed		30-Day Clozapine Washout Cohort Re-entry not Allowed		183-Day Clozapine Washout Cohort Re-entry not Allowed	
	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded	Remaining	Excluded
Members meeting enrollment and demographic requirements								
Enrolled at any point during the query period	118,473,915	N/A[2]	118,473,915	N/A	118,473,915	N/A	118,473,915	N/A
Had required coverage type (medical and/or drug coverage)	87,408,345	31,065,570	87,408,345	31,065,570	87,408,345	31,065,570	87,408,345	31,065,570
Enrolled during specified age range	81,791,681	5,616,664	81,791,681	5,616,664	81,791,681	5,616,664	81,791,681	5,616,664
Met demographic requirements (sex, race, and Hispanic	81,769,896	21,785	81,769,896	21,785	81,769,896	21,785	81,769,896	21,785
Members with a valid index event								
Had any cohort-defining claim during the query period	15,198	81,754,698	15,198	81,754,698	15,198	81,754,698	15,198	81,754,698
Claim recorded during specified age range	15,192	6	15,192	6	15,192	6	15,192	6
Episode defining index claim recorded during the query	14,533	659	14,282	910	14,533	659	14,282	910
Members with required pre-index history								
Had sufficient pre-index continuous enrollment	6,698	7,835	5,306	8,976	6,698	7,835	5,306	8,976
Met inclusion and exclusion criteria[3]	6,698	0	5,306	0	1,595	5,103	1,053	4,253
No evidence of Complete Correspondence	N/A	N/A	N/A	N/A	N/A	5,103	N/A	4,253
Final cohort								
Number of members	6,698	N/A	5,306	N/A	1,595	N/A	1,053	N/A
Number of episodes	6,698	N/A	5,306	N/A	1,595	N/A	1,053	N/A

[1]Complete correspondence is defined as having evidence of at least as many ANC laboratory results as ANC screening procedure codes during the first six months of the clozapine treatment episode.

[2]N/A: Not Applicable

[3]Patients can meet multiple inclusion and/or exclusion criteria; therefore, the total number of patients excluded overall may not equal the sum of all patients in each criterion.

Appendix A. Dates of Available Data for Each Data Partner (DP) as of Request Distribution Date (July 8, 2024 for cder_mpl1r_wp284 and July 17, 2024 for cder_mpl1p_wp094)*

Masked DP ID	DP Start Date	DP End Date[1]
DP01*	01/01/2005	07/31/2022
DP02*	01/01/2000	04/30/2023
DP03	01/01/2000	01/31/2024
DP04*	01/01/2007	10/31/2023
DP05	01/01/2010	06/30/2023
DP06*	01/01/2004	07/31/2023
DP07*	01/01/2000	01/31/2024
DP08	01/01/2008	01/31/2024
DP09*	01/01/2000	10/31/2022
DP10	01/01/2014	12/31/2021
DP11	01/01/2008	08/31/2023
DP12*	01/01/2006	10/31/2023
DP13*	01/01/2000	08/31/2022

*All 13 DPs contributed to data in Tables 1a-1d and Tables 3a and 3b. The DPs marked with asterisks were the sole contributors to the remaining tables.

[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.

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

Generic Name	Brand Name
Clozapine	
clozapine	clozapine
clozapine	Clozaril
clozapine	FazaClo
clozapine	Versacloz

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes and Sentinel Operations Center (SOC) Defined Lab Codes Used to Define Outcomes in this Request

Code	Description	Code Type	Code Category	Lab Result
Severe Neutropenia Diagnosis (Agranulocytosis)				
D70.2	Other drug-induced agranulocytosis	ICD-10-CM	Diagnosis	N/A[1]
Severe Neutropenia Lab				
L0032013010104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013010204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013010304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013010404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013010504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013020104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013020204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013020304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013020404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013020504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013070104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013070204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013070304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013070404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
L0032013070504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	<0.5 k/ul
Moderate Neutropenia Lab				
L0032013010104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013010204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013010304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013010404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013010504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013020104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013020204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013020304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013020404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013020504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013070104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013070204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013070304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
L0032013070404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul

Appendix C. List of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes and Sentinel Operations Center (SOC) Defined Lab Codes Used to Define Outcomes in this Request

Code	Description	Code Type	Code Category	Lab Result
L0032013070504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	0.5-1.0 k/ul
		Mild Neutropenia Lab		
L0032013010104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013010204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013010304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013010404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013010504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013020104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013020204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013020304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013020404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013020504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013070104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013070204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013070304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013070404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul
L0032013070504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab	1-1.5 k/ul

[1]N/A: Not Applicable
ANC = Absolute Neutrophil Count

Appendix D. List of Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, Revenue Codes, and Sentinel Operations Center (SOC) Defined Lab Codes Used to Define Inclusions in this Request

Code	Description	Code Type	Code Category
	Aboslute Neutrophil Count (ANC) Procdure		
80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)	CPT-4	Procedure
80055	Obstetric panel This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)	CPT-4	Procedure
85004	Blood count; automated differential WBC count	CPT-4	Procedure
85007	Blood count; blood smear, microscopic examination with manual differential WBC count	CPT-4	Procedure
85008	differential WBC count	CPT-4	Procedure
85009	Blood count; manual differential WBC count, buffy coat	CPT-4	Procedure
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	CPT-4	Procedure
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	CPT-4	Procedure
85032	Blood count; manual cell count (erythrocyte, leukocyte, or platelet) each	CPT-4	Procedure
85048	Blood count; leukocyte (WBC), automated	CPT-4	Procedure
G0306	Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count	HCPCS	Procedure
G0307	Complete CBC, automated (HgB, HCT, RBC, WBC; without platelet count)	HCPCS	Procedure
0305	Laboratoryoratory-Hematology	Revenue	Revenue
	Aboslute Neutrophil Count (ANC) Lab		
L003201301	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201301	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201301	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201301	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201301	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201302	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201302	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201302	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201302	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201302	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201307	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201307	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201307	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L003201307	ANC Lab (K/UL)	SOC Defined Quantitative	Lab

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

Generic Name	Brand Name
Antimicrobials	
cephalexin	cephalexin
cefadroxil	cefadroxil
ciprofloxacin HCl	ciprofloxacin HCl
amoxicillin/potassium clavulanate	amoxicillin-pot clavulanate
clindamycin HCl	clindamycin HCl
tafenoquine succinate	Arakoda
doxycycline hyclate	doxycycline hyclate
dicloxacillin sodium	dicloxacillin
metronidazole	metronidazole
amoxicillin	amoxicillin
nitrofurantoin macrocrystal	nitrofurantoin macrocrystal
erythromycin base	Ery-Tab
erythromycin base	erythromycin
isoniazid	isoniazid
penicillin V potassium	penicillin V potassium
cefaclor	cefaclor
pyrazinamide	pyrazinamide
sulfamethoxazole/trimethoprim	sulfamethoxazole-trimethoprim
acyclovir	acyclovir
atovaquone/proguanil HCl	Malarone
nitrofurantoin monohydrate/macrocrystals	nitrofurantoin monohyd/m-cryst
fluconazole	fluconazole
emtricitabine/tenofovir disoproxil fumarate	Truvada
clarithromycin	clarithromycin
ceftriaxone sodium	ceftriaxone
azithromycin	azithromycin
rifampin	rifampin
efavirenz/emtricitabine/tenofovir disoproxil fumarate	Atripla
penicillin G benzathine	Bicillin L-A
cefdinir	cefdinir
terbinafine HCl	terbinafine HCl
raltegravir potassium	Isentress
valacyclovir HCl	valacyclovir
levofloxacin	levofloxacin
oseltamivir phosphate	Tamiflu
atovaquone/proguanil HCl	atovaquone-proguanil
darunavir	Prezista
doxycycline monohydrate	doxycycline monohydrate
atazanavir sulfate	Reyataz
abacavir sulfate/dolutegravir sodium/lamivudine	Triumeq
darunavir ethanolate/cobicistat	Prezcobix
atazanavir sulfate/cobicistat	Evotaz
cefprozil	cefprozil
cefuroxime axetil	cefuroxime axetil
elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide	Genvoya
minocycline HCl	minocycline
mefloquine HCl	mefloquine

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

Generic Name	Brand Name
rifaximin	Xifaxan
hydroxychloroquine sulfate	hydroxychloroquine
ethambutol HCl	Myambutol
oseltamivir phosphate	oseltamivir
famciclovir	famciclovir
moxifloxacin HCl	moxifloxacin
baloxavir marboxil	Xofluza
cefazolin sodium	cefazolin
fosfomycin tromethamine	fosfomycin tromethamine
emtricitabine/tenofovir disoproxil fumarate	emtricitabine-tenofovir (TDF)
ketoconazole	ketoconazole
doravirine	Pifeltro
maraviroc	Selzentry
bictegravir sodium/emtricitabine/tenofovir alafenamide fumar	Biktarvy
molnupiravir	Lagevrio (EUA)
acyclovir	Zovirax
amoxicillin	Amoxil
cefaclor	Ceclor
cefadroxil	Duricef
amoxicillin/potassium clavulanate	Augmentin
erythromycin base	E-Mycin
erythromycin stearate	Erythrocin (as stearate)
erythromycin ethylsuccinate	E.E.S. Granules
erythromycin ethylsuccinate	E.E.S. 400
erythromycin base	Eryc
erythromycin ethylsuccinate	EryPed 400
erythromycin ethylsuccinate/sulfisoxazole acetyl	Pediazole
erythromycin base	PCE
sulfamethoxazole/trimethoprim	Septra
norfloxacin	Noroxin
sulfisoxazole	sulfisoxazole
nystatin	nystatin
rifampin	Rifadin
clindamycin HCl	Cleocin HCl
cephradine	cephradine
griseofulvin ultramicrosize	Fulvicin P/G
ceftriaxone sodium	Rocephin
cefonicid sodium	Monocid
lincomycin HCl	Lincocin
amoxicillin	Wymox
ampicillin sodium	ampicillin sodium
penicillin G benzathine/penicillin G procaine	Bicillin C-R
ciprofloxacin HCl	Cipro
ampicillin trihydrate	ampicillin
griseofulvin, microsize	Grifulvin V
zidovudine	Retrovir
cefuroxime axetil	Ceftin
cefazolin sodium	Ancef

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

Generic Name	Brand Name
penicillin G benzathine	penicillin G benzathine
erythromycin ethylsuccinate	EryPed 200
erythromycin ethylsuccinate/sulfisoxazole acetyl	erythromycin-sulfisoxazole
dapsone	dapsone
penicillin G procaine	Wycillin
quinine sulfate	quinine sulfate
erythromycin ethylsuccinate	erythromycin ethylsuccinate
tetracycline HCl	tetracycline
spectinomycin HCl	Trobicin
cefotaxime sodium	Claforan
griseofulvin, microsize	Grisactin
cefixime	Suprax
penicillin V potassium	Veetids
minocycline HCl	Minocin
mefloquine HCl	Lariam
erythromycin ethylsuccinate	E.E.S. 200
gentamicin sulfate	gentamicin
trimethoprim	trimethoprim
ofloxacin	Floxin
fluconazole	Diflucan
clarithromycin	Biaxin
erythromycin estolate	erythromycin estolate
nitrofurantoin monohydrate/macrocrystals	Macrobid
cefprozil	Cefzil
mebendazole	Vermox
loracarbef	Lorabid
rimantadine HCl	Flumadine
chloroquine phosphate	Aralen
zalcitabine	Hivid
rifabutin	Mycobutin
sulfisoxazole acetyl	Gantrisin Pediatric
stavudine	Zerit
cefpodoxime proxetil	Vantin
pentamidine isethionate	Nebupent
cycloserine	Seromycin
lamivudine	Epivir
azithromycin	Zithromax
saquinavir mesylate	Invirase
valacyclovir HCl	Valtrex
didanosine/calcium carbonate/magnesium	Videx
didanosine/calcium carbonate/magnesium	Videx Buffered
ciprofloxacin HCl	Cipro Cystitis
terbinafine HCl	Lamisil
ceftriaxone sodium/lidocaine HCl	Rocephin IM Convenience
cefaclor	Ceclor CD
levofloxacin	Levaquin
azithromycin	Zithromax Z-Pak
didanosine	Videx 4 gram Pediatric

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

Generic Name	Brand Name
lamivudine/zidovudine	Combivir
metronidazole	Flagyl
famciclovir	Famvir
fosfomycin tromethamine	Monurol
nelfinavir mesylate	Viracept
ceftibuten	Cedax
nevirapine	Viramune
delavirdine mesylate	Rescriptor
saquinavir	Fortovase
efavirenz	Sustiva
ritonavir	Norvir
minocycline HCl	Dynacin
vancomycin HCl	vancomycin
meropenem	Merrem
alatrofloxacin mesylate	Trovan
ceftazidime	Fortaz
cefepime HCl	Maxipime
cefotetan disodium	Cefotan
ganciclovir sodium	Cytovene
metronidazole HCl	Flagyl (as HCl)
ritonavir	Norvir Soft Gelatin
amprenavir/vitamin E	Agenerase
zanamivir	Relenza Diskhaler
quinupristin/dalfopristin	Synercid
itraconazole	Sporanox
cefdinir	Omnicef
abacavir sulfate	Ziagen
sulfamethoxazole/trimethoprim	Sulfatrim
gatifloxacin	Tequin
moxifloxacin HCl	Avelox
clarithromycin	Biaxin XL
capreomycin sulfate	Capastat
ethionamide	Trecator-SC
mebendazole	mebendazole
penicillin V potassium	Veetids 250
aztreonam	Azactam
lopinavir/ritonavir	Kaletra
moxifloxacin HCl	Avelox ABC Pack
metronidazole	Flagyl ER
trimethoprim	Primsol
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Urimax
dirithromycin	Dynabac D5-Pak
didanosine	Videx EC
abacavir sulfate/lamivudine/zidovudine	Trizivir
chloroquine phosphate	chloroquine phosphate
amoxicillin/potassium clavulanate	Augmentin ES-600
ceftizoxime sodium	Cefizox

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

Generic Name	Brand Name
tenofovir disoproxil fumarate	Viread
atovaquone/proguanil HCl	Malarone Pediatric
ribavirin/interferon alfa-2b,recomb.	Rebetron 1200
azithromycin	Zithromax TRI-PAK
lamivudine	Epivir HBV
amoxicillin/potassium clavulanate	Augmentin XR
ciprofloxacin/ciprofloxacin HCl	Cipro XR
emtricitabine	Emtriva
fosamprenavir calcium	Lexiva
levofloxacin	Levaquin Leva-Pak
telithromycin	Ketek Pak
abacavir sulfate/lamivudine	Epzicom
paromomycin sulfate	Humatin
adefovir dipivoxil	Hepsera
paromomycin sulfate	paromomycin
sulfadiazine	sulfadiazine
didanosine	didanosine
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	Prosed/DS
tipranavir	Aptivus
tinidazole	Tindamax
azithromycin	Zmax
rimantadine HCl	rimantadine
enfuvirtide	Fuzeon
ciprofloxacin/ciprofloxacin HCl	ciprofloxacin (mixture)
ethionamide	Trecator
linezolid	Zyvox
etravirine	Intelence
stavudine	stavudine
artemether/lumefantrine	Coartem
zidovudine	zidovudine
nevirapine	Viramune XR
emtricitabine/rilpivirine HCl/tenofovir disoproxil fumarate	Complera
abacavir sulfate	abacavir
elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil	Stribild
amikacin sulfate	amikacin
dolutegravir sodium	Tivicay
lamivudine/zidovudine	lamivudine-zidovudine
indinavir sulfate	Crixivan
levofloxacin	levofloxacin (bulk)
tobramycin sulfate	tobramycin sulfate (bulk)
vancomycin HCl	vancomycin (bulk)
voriconazole	voriconazole (bulk)
sulfacetamide sodium	sulfacetamide sodium (bulk)
doxycycline monohydrate	doxycycline monohydrate (bulk)
chloroquine phosphate	chloroquine phosphate (bulk)
ceftazidime	ceftazidime (bulk)
gatifloxacin	gatifloxacin sesquihydr (bulk)

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

Generic Name	Brand Name
lincomycin HCl	lincomycin HCl (bulk)
ceftazidime	Tazicef
oxacillin sodium	Bactocill
ticarcillin disodium	Ticar
tobramycin sulfate/sodium chloride	tobramycin in 0.9 % NaCl
acyclovir sodium	acyclovir sodium
erythromycin lactobionate	Erythrocin
erythromycin lactobionate	erythromycin lactobionate
clindamycin phosphate/dextrose 5 % in water	clindamycin in 5 % dextrose
amphotericin B	amphotericin B
cefuroxime sodium	cefuroxime sodium
ombitasvir/paritaprevir/ritonavir/dasabuvir sodium	Viekira XR
glecaprevir/pibrentasvir	Mavyret
ombitasvir/paritaprevir/ritonavir	Technivie
ombitasvir/paritaprevir/ritonavir/dasabuvir sodium	Viekira Pak
clarithromycin	Biaxin XL Pak
ribavirin	Moderiba
ribavirin	Moderiba Dose Pack
erythromycin ethylsuccinate	EryPed
methenamine mandelate	methenamine mandelate
fluconazole in sodium chloride, iso-osmotic	fluconazole in NaCl (iso-osm)
cefoxitin sodium	cefoxitin
itraconazole	itraconazole
tigecycline	tigecycline
entecavir	entecavir
daptomycin	daptomycin
plazomicin sulfate	Zemdri
ethambutol HCl	ethambutol
doxycycline hyclate	Doryx
griseofulvin, microsize	griseofulvin microsize
nitrofurantoin	nitrofurantoin
valganciclovir HCl	valganciclovir
methenamine/methylene blue/salicylate/sodium/hyoscyamine	Disurex D/S
doxycycline monohydrate/omega-3 combination no.1/Eye Mask	Nutridox
cephalexin	Keflex
linezolid	linezolid
rifabutin	rifabutin
voriconazole	voriconazole
flucytosine	flucytosine
lamivudine	lamivudine
ritonavir	ritonavir
tenofovir disoproxil fumarate	tenofovir disoproxil fumarate
atazanavir sulfate	atazanavir
posaconazole	posaconazole
atovaquone	atovaquone
demeclocycline HCl	demeclocycline

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

Generic Name	Brand Name
methenamine hippurate	methenamine hippurate
ribavirin	ribavirin
primaquine phosphate	primaquine
tobramycin sulfate	tobramycin sulfate
rifampin/isoniazid	IsonaRif
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	URIMAR-T
acyclovir, micronized	acyclovir, micronized (bulk)
ceftaroline fosamil acetate	Teflaro
ceftazidime/avibactam sodium	Avycaz
clindamycin phosphate	clindamycin phosphate
caspofungin acetate	caspofungin
nitrofurantoin macrocrystal	Macrodantin
doxycycline monohydrate	Monodox
sarecycline HCl	Seysara
doxycycline hyclate	Acticlate
erythromycin ethylsuccinate/sulfisoxazole acetyl	Eryzole
gentamicin sulfate/PF	gentamicin sulfate (ped) (PF)
cefotaxime sodium	cefotaxime
itraconazole, micronized	itraconazole, micronized(bulk)
acyclovir	acyclovir (bulk)
fluconazole	fluconazole (bulk)
terbinafine HCl	terbinafine (bulk)
clotrimazole	clotrimazole (bulk)
ketoconazole, micronized	ketoconazole, micro (bulk)
miconazole	miconazole (bulk)
nevirapine	nevirapine
polymyxin B sulfate	polymyxin B sulfate
pyrimethamine	pyrimethamine
albendazole	Albenza
pyrimethamine	Daraprim
mebendazole	Emverm
benzoic acid	benzoic acid (bulk)
clioquinol	clioquinol (bulk)
neomycin sulfate	neomycin sulfate (bulk)
quinine sulfate	quinine sulfate (bulk)
sulfacetamide sodium	Sodium Sulfacetamide
sulfadiazine	sulfadiazine (bulk)
sulfamerazine	sulfamerazine (bulk)
sulfanilamide	sulfanilamide (bulk)
sulfapyridine	sulfapyridine (bulk)
sulfisoxazole	sulfisoxazole (bulk)
sulfathiazole	sulfathiazole (bulk)
thymol	thymol (bulk)
thymol iodide	thymol iodide (bulk)
zinc undecylenate	zinc undecylenate (bulk)
isoniazid	isoniazid (bulk)
sodium caprylate	sodium caprylate (bulk)

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

Generic Name	Brand Name
bacitracin	bacitracin (bulk)
tetracycline HCl	tetracycline HCl (bulk)
clindamycin HCl	clindamycin HCl (bulk)
gentamicin sulfate	gentamicin (bulk)
itraconazole	itraconazole (bulk)
ketoconazole	ketoconazole (bulk)
miconazole nitrate	miconazole nitrate (bulk)
metronidazole	metronidazole (bulk)
metronidazole benzoate	metronidazole benzoate (bulk)
amphotericin B	amphotericin B (bulk)
doxycycline hyclate	doxycycline hyclate (bulk)
amikacin sulfate	amikacin sulfate (bulk)
clindamycin phosphate	clindamycin phosphate (bulk)
cefazolin sodium in 0.9 % sodium chloride	cefazolin in 0.9% sod chloride
vancomycin in 0.9 % sodium chloride	vancomycin in 0.9 % sodium chl
penicillin G potassium in 0.9 % sodium chloride	penicillin G pot-0.9% sodchlor
ampicillin sodium/sulbactam sodium	ampicillin-sulbactam
methenamine/sodium salicylate	Antibacterial-Urinary Pain Rlf
interferon alfacon-1	Infergen
cefpodoxime proxetil	cefpodoxime
artesunate	artesunate
meropenem	meropenem
albendazole	albendazole
griseofulvin ultramicrosize	griseofulvin ultramicrosize
darunavir	darunavir
etravirine	etravirine
clindamycin palmitate HCl	Clindamycin Pediatric
metronidazole in sodium chloride	metronidazole in NaCl (iso-os)
vancomycin HCl	Vancocin
hydroxychloroquine sulfate	Sovuna
hydroxychloroquine sulfate	Plaquenil
piperacillin sodium/tazobactam sodium	piperacillin-tazobactam
cefepime HCl	cefepime
fluconazole in dextrose, iso-osmotic	fluconazole in dextrose(iso-o)
adefovir dipivoxil	adefovir
micafungin sodium	micafungin
doripenem	doripenem
ertapenem sodium	ertapenem
amikacin	amikacin (bulk)
azithromycin	azithromycin (bulk)
chloramphenicol	chloramphenicol (bulk)
ciprofloxacin HCl	ciprofloxacin (bulk)
colistin (as colistimethate sodium)	colistimethate sodium (bulk)
praziquantel	praziquantel (bulk)
sulfamethoxazole	sulfamethoxazole (bulk)
tobramycin	tobramycin (bulk)
pyrantel pamoate	Pin-Rid
amoxicillin	Trimox

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

Generic Name	Brand Name
cephradine	Velosef
ampicillin trihydrate	Principen
amphotericin B	Fungizone (Lab Use)
nystatin	Mycostatin
tetracycline HCl	Sumycin
penicillin G potassium	penicillin G potassium
amikacin sulfate	Amikin
kanamycin sulfate	Kantrex
nafcillin sodium	nafcillin
dicloxacillin sodium	Dynapen
oxacillin sodium	oxacillin
chloramphenicol sod succinate	chloramphenicol sod succinate
ganciclovir sodium	ganciclovir sodium
imipenem/cilastatin sodium	imipenem-cilastatin
bacitracin	bacitracin
levofloxacin/dextrose 5 % in water	levofloxacin in D5W
kanamycin sulfate	kanamycin
piperacillin sodium	piperacillin
colistin (as colistimethate sodium)	colistin (colistimethate Na)
cefotetan disodium	cefotetan
moxifloxacin HCl in sodium acetate and sulfate,water,iso-osm	moxifloxacin-sod.ace,sul-water
sulfamethoxazole/trimethoprim	Bactrim
sulfamethoxazole/trimethoprim	Bactrim DS
quinine sulfate	Qualaquin
rifamycin sodium	Aemcolo
lincomycin HCl	lincomycin
cefixime	cefixime
ledipasvir/sofosbuvir	ledipasvir-sofosbuvir
sofosbuvir/velpatasvir	sofosbuvir-velpatasvir
ciprofloxacin HCl	ProQuin XR
isavuconazonium sulfate	Cresemba
amphotericin B liposome	AmBisome
micafungin sodium	Mycamine
telavancin HCl	Vibativ
ceftizoxime sodium/dextrose, iso-osmotic	Cefizox in dextrose (iso-osm)
foscarnet sodium	Foscavir
cefotetan in dextrose	Cefotan in dextrose
cidofovir	cidofovir (bulk)
dapsone	dapsone (bulk)
rifaximin	rifaximin (bulk)
amoxicillin/potassium clavulanate	amoxicillin-pot clavula (bulk)
efavirenz	efavirenz
emtricitabine	emtricitabine
abacavir sulfate/lamivudine	abacavir-lamivudine
efavirenz/emtricitabine/tenofovir disoproxil fumarate	efavirenz-emtricitabin-tenofov
clindamycin palmitate HCl	clindamycin palmitate HCl
linezolid in dextrose 5 % in water	linezolid in dextrose 5%

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

Generic Name	Brand Name
amphotericin B liposome	amphotericin B liposome
cefazolin sodium/dextrose 5 % in water	cefazolin in dextrose 5 %
vancomycin in 5 % dextrose in water	vancomycin in dextrose 5 %
cefazolin sodium/water for injection,sterile	cefazolin in sterile water
gentamicin sulfate/sodium citrate	gentamicin-sodium citrate
cidofovir	cidofovir
pentamidine isethionate	pentamidine
foscarnet sodium	foscarnet
doxycycline monohydrate	Avidoxy
doxycycline monohydrate/salicylic acid/octinoxate/zinc oxide	Avidoxy DK
methenamine/methylene blue/sod	UroAv-81
phos/p.salicylate/hyoscyamine	
methenamine/methylene blue/sod	UroAv-B
phos/p.salicylate/hyoscyamine	
quinacrine HCl	quinacrine (bulk)
vancomycin HCl	Firvanq
valacyclovir HCl	valacyclovir (bulk)
cefazolin sodium/dextrose, iso-osmotic	cefazolin in dextrose (iso-os)
cefuroxime sodium/dextrose, iso-osmotic	cefuroxime-dextrose (iso-osm)
cefoxitin sodium/dextrose, iso-osmotic	cefoxitin in dextrose, iso-osm
ceftazidime in dextrose 5 % and water	ceftazidime in D5W
ceftriaxone sodium in iso-osmotic dextrose	ceftriaxone in dextrose,iso-os
cefotetan disodium in iso-osmotic dextrose	cefotetan in dextrose, iso-osm
meropenem in 0.9 % sodium chloride	meropenem-0.9% sodium chloride
cefepime HCl in dextrose 5 % in water	cefepime in dextrose 5 %
metronidazole in sodium chloride	Metro I.V.
gentamicin sulfate in sodium chloride, iso-osmotic	gentamicin in NaCl (iso-osm)
erythromycin stearate	erythromycin stearate
ciprofloxacin	ciprofloxacin
ribavirin	Virazole
flucytosine	Ancobon
griseofulvin ultramicrosize	Gris-PEG (ultramicrosize)
minocycline HCl	Solodyn
ciprofloxacin lactate/dextrose 5 % in water	ciprofloxacin in 5 % dextrose
ceftriaxone sodium in iso-osmotic dextrose	Rocephin in dextrose (iso-osm)
cefoxitin sodium/dextrose 5 % in water	Mefoxin in dextrose (iso-osm)
ceftazidime in dextrose, iso-osmotic	Tazicef in dextrose
cefotaxime sodium/dextrose, iso-osmotic	Claforan in dextrose(iso-osm)
cephalothin sodium/dextrose 5 % in water	cephalothin in dextrose 5 %
daptomycin in 0.9 % sodium chloride	daptomycin in 0.9 % sod chlor
oxacillin sodium in iso-osmotic dextrose	oxacillin in dextrose(iso-osm)
nafcillin in dextrose, iso-osmotic	nafcillin in dextrose iso-osm
penicillin G potassium/dextrose-water	penicillin G pot in dextrose
cefepime HCl in iso-osmotic dextrose	cefepime in dextrose,iso-osm
cefamandole nafate/dextrose 5 % in water	Mandol/D5W
clindamycin phosphate in 0.9 % sodium chloride	clindamycin in 0.9 % sod chlor
piperacillin and tazobactam in dextrose, iso-osmotic	Zosyn in dextrose (iso-osm)
moxifloxacin HCl in sodium chloride, iso-osmotic	Avelox in NaCl (iso-osmotic)

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

Generic Name	Brand Name
praziquantel	Biltricide
nifurtimox	Lampit
ciprofloxacin lactate/dextrose 5 % in water	Cipro in D5W
methenamine mandelate/sodium phosphate,monobasic	Uroqid-Acid No.2
ciprofloxacin lactate	ciprofloxacin lactate
amikacin sulfate/PF	amikacin (PF)
sparfloxacin	Zagam
nystatin	Bio-Statin
methylene blue/potassium salicylate/salicylamide/mag/caffein	Uro-Tech
methenamine/methylene blue/benzoic acid/salicylat/hyoscyamin	Hyophen
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Phosphasal
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Ustell
tinidazole	tinidazole
peramivir/PF	Rapivab (PF)
didanosine	Videx 2 gram Pediatric
daclatasvir dihydrochloride	Daklinza
entecavir	Baraclude
aztreonam/dextrose-water	Azactam in dextrose (iso-osm)
gatifloxacin/dextrose 5 % in water	Tequin in dextrose 5 %
tipranavir/vitamin E TPGS	Aptivus (with vitamin E)
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	Usept
methenamine mandelate/sodium phosphate,monobasic	Utac
neomycin sulfate	neomycin
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uramit MB
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Hyolev MB
methenamine/sod phosph,monobasic/methylene blue/hyoscyamine	Urolet MB
methenamine/methylene blue/benzoic acid/salicylat/hyoscyamin	Urophen MB
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Azuphen MB
methenamine/sod phosph,monobasic/methylene blue/hyoscyamine	Indiomin MB
clindamycin phosphate	Clin Single Use
lopinavir/ritonavir	lopinavir-ritonavir
maraviroc	maraviroc
pyrantel pamoate	PinAway
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Urocar D/S
nitrofurantoin	Furadantin
thalidomide	Thalomid
lamivudine/tenofovir disoproxil fumarate	Temixys

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

Generic Name	Brand Name
sulfamethoxazole/trimethoprim	Sulfamar
cloxacillin sodium	cloxacillin
ketoconazole	Nizoral
erythromycin ethylsuccinate/sulfisoxazole acetyl	Pediagen
griseofulvin, microsize	Fulvicin U/F
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	Urised
brincidofovir	Tembexa
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	Urinary Antiseptic
ofloxacin	ofloxacin
taurolidine in heparin sodium, porcine	Defencath
cefditoren pivoxil	Spectracef
gemifloxacin mesylate	Factive
cefuroxime sodium	Zinacef
ceftazidime sodium in iso-osmotic dextrose	Fortaz in dextrose 5 %
cefuroxime sodium/dextrose, iso-osmotic	Zinacef in dextrose (iso-osm)
cefuroxime sodium/water for injection,sterile	Zinacef in Sterile Water
cephalexin	Daxbia
NYSTATIN/LIDOCAINE HCL/DIPHENHYDRAMINE HCL	First-BXN
NYSTATIN/HYDROCORTISONE/DIPHENHYDRAMINE HCL	FIRST-Duke's
NYSTATIN/TETRACYCLINE HCL/HYDROCORTISONE/DIPHENHYDRAMINE HCL	FIRST-Mary's Mouthwash
pyrantel pamoate	Pinworm Treatment
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	MSP-Blu
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Utrona
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	MHP-A
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	Uritact DS
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	Uritact-EC
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Utrona-C
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uticap
penciclovir	penciclovir (bulk)
albendazole	albendazole (bulk)
mebendazole	mebendazole (bulk)
pyrimethamine	pyrimethamine (bulk)
ivermectin	ivermectin (bulk)
nitazoxanide	nitazoxanide (bulk)
nitrofurantoin	nitrofurantoin (bulk)
moxifloxacin HCl	moxifloxacin HCl (bulk)
flucytosine	flucytosine (bulk)
rifampin	rifampin (bulk)

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

Generic Name	Brand Name
rifampin/isoniazid	Rifamate
demeclocycline HCl	Declomycin
valganciclovir HCl	Valcyte
voriconazole	Vfend
2-deoxy-D-glucose	2-deoxy-D-glucose (bulk)
cephalexin HCl	Keftab
doxycycline monohydrate	Adoxa
cycloserine	cycloserine
methenamine/sodium salicylate	Cystex Plus (methenamine-sal)
dalbavancin HCl	Dalvance
ivermectin	ivermectin
methenamine/sod phosph,monobasic/methylene blue/hyoscyamine	Urogesic-Blue
doxycycline hyclate	Doxy-Caps
cephalexin	ED A-Ceph
pyrantel pamoate	Pin-X
tobramycin sulfate	Nebcin
cefazolin sodium	Kefzol
cefamandole nafate	Mandol
ceftazidime	Tazidime
cefuroxime sodium	Kefurox
gentamicin sulfate/sodium chloride	gentamicin in 0.9 % sodium chl
doxycycline monohydrate/benzoyl peroxide	BenoxylDoxy 30
doxycycline monohydrate/benzoyl peroxide	BenoxylDoxy 60
doxycycline monohydrate/benzoyl peroxide	BenzoDox 30
doxycycline monohydrate/benzoyl peroxide	BenzoDox 60
doxycycline monohydrate	Okebo
minocycline HCl	CoreMino
griseofulvin	griseofulvin (bulk)
amphotericin B lipid complex	Abelcet
acyclovir	Sitavig
minocycline HCl	Minolira ER
quinine sulfate	Quinerva
tetracycline HCl	Achromycin V
nystatin	Nilstat
vancomycin HCl	Vancoled
methylene blue	Urolene Blue
methenamine/methylene blue/benzoic acid/salicylat/hyoscyamin	Prosed/DS (atropine Free)
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	Prosed EC
ganciclovir	ganciclovir
benznidazole	benznidazole
nystatin	nystatin (bulk)
sulfacetamide sodium, monohydrate	sulfacetamide sod, mono (bulk)
nitrofurazone	nitrofurazone (bulk)
sulfurated potash	sulfurated potash (bulk)
thiabendazole	thiabendazole (bulk)

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

Generic Name	Brand Name
sodium propionate	sodium propionate (bulk)
erythromycin base	erythromycin (bulk)
tinidazole	tinidazole (bulk)
iodoquinol	iodoquinol (bulk)
kanamycin sulfate	kanamycin (bulk)
polymyxin B sulfate,micronized	polymyxin B sulf,micron.(bulk)
trimethoprim	trimethoprim (bulk)
pyrantel pamoate	pyrantel pamoate (bulk)
streptomycin sulfate	streptomycin sulfate (bulk)
oxytetracycline HCl	oxytetracycline (bulk)
clarithromycin	clarithromycin (bulk)
econazole nitrate	econazole nitrate (bulk)
minocycline HCl	minocycline HCl (bulk)
vancomycin in 0.9 % sodium chloride/preservative free	vancomycin-0.9 % sod chlor(PF)
mafenide acetate	mafenide acetate (bulk)
doxycycline hyclate	Doxy-100
aztreonam	aztreonam
pentamidine isethionate	Pentam
acyclovir sodium in 0.9 % sodium chloride	acyclovir in 0.9 % sodium chlr
doxycycline monohydrate	Oracea
miconazole	Oravig
ribavirin	Copegus
peginterferon alfa-2a	Pegasys
peginterferon alfa-2a	Pegasys Convenience Pack
peginterferon alfa-2a	Pegasys ProClick
penicillin G sodium	penicillin G sodium
cidofovir	Vistide
elvitegravir	Vitekta
sofosbuvir	Sovaldi
ledipasvir/sofosbuvir	Harvoni
emtricitabine/tenofovir alafenamide fumarate	Descovy
emtricitabine/rilpivirine HCl/tenofovir alafenamide fumarate	Odefsey
sofosbuvir/velpatasvir	Epclusa
tenofovir alafenamide	Vemlidy
sofosbuvir/velpatasvir/voxilaprevir	Vosevi
remdesivir	remdesivir
remdesivir	Veklury
lenacapavir sodium	Sunlenca
ceftazidime/arginine	Ceptaz
ticarcillin disodium/potassium clavulanate	Timentin
atovaquone	Mepron
tafenoquine succinate	Krintafel
acyclovir sodium	Zovirax (as sodium)
sulfacytine	Renoquid
iodoquinol	Yodoxin
Methenamine/Methylene Blue/Benzoic/Phenyl Sal/Atropin/Hyoscy	Urinary Antiseptic F.C.
erythromycin ethylsuccinate	erythromycin ethylsuccin(bulk)

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

Generic Name	Brand Name
hydroxychloroquine sulfate	hydroxychloroquine sulf (bulk)
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Utira
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Utira-C
interferon gamma-1b,recomb.	Actimmune
nafcillin sodium	Nallpen
ampicillin sodium	Totacillin-N
gentamicin sulfate/PF	gentamicin sulfate (PF)
linezolid in 0.9 % sodium chloride	linezolid-0.9% sodium chloride
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	Trac 2x
methenamine/sodium salicylate	AZO Urinary Tract Defense
terbinafine HCl/hydroxypropyl chitosan	Terbinex
amikacin sulfate liposomal with nebulizer accessories	Arikayce
amphotericin B cholesteryl sulfate	Amphotec
aminosalicylic acid	Paser
levofloxacin/dextrose 5 % in water	Levaquin in 5 % dextrose
itraconazole	Sporanox Pulsepak
simeprevir sodium	Olysio
rilpivirine HCl	Edurant
bedaquiline fumarate	Sirturo
darunavir eth/cobicistat/emtricitabine/tenofovir alafenamide	Symtuza
colistin (as colistimethate sodium)	Coly-Mycin M
doxycycline hyclate	Targadox
minocycline HCl	Ximino
ribavirin	Ribasphere RibaPak
ribavirin	Ribasphere
metronidazole	Likmez
trimethoprim	Trimpex
sulbactam sodium/durlobactam sodium	Xacduro
sulfamethoxazole/trimethoprim	Sultrex
efavirenz/lamivudine/tenofovir disoproxil fumarate	efavirenz-lamivu-tenofov disop
sulfadiazine sodium	sulfadiazine sodium (bulk)
amoxicillin	amoxicillin (bulk)
trimethoprim, micronized	trimethoprim, micro (bulk)
fenbendazole	fenbendazole (bulk)
metronidazole, micronized	metronidazole, micro (bulk)
doxycycline hyclate	LymePak
lincomycin HCl	Lincoject
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Urin DS
secnidazole	Solosec
nitazoxanide	Alinia
nitazoxanide	nitazoxanide
abacavir sulfate/lamivudine/zidovudine	abacavir-lamivudine-zidovudine
ceftibuten	ceftibuten

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

Generic Name	Brand Name
sulfisoxazole/phenazopyridine HCl	Azo-Sulfisoxazole
methenamine/methylene blue/benz ac/salicylate/atrop/hyoscy	Urinary Antiseptic #2
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uretron D-S
doxycycline hyclate	Doxy-Lemmon
metronidazole	Metryl
ampicillin trihydrate	Marcillin
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	UR N-C
itraconazole	Tolsura
doxycycline hyclate	Doryx MPC
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Urelle
oritavancin diphosphate	Orbactiv
minocycline HCl	Vectrin
doxycycline hyclate	Morgidox
doxycycline hyclate/skin cleanser combination no.19	Morgidox 1x100
doxycycline hyclate/skin cleanser combination no.19	Morgidox 2x100
doxycycline hyclate/skin cleanser combination no.19	Morgidox 1x 50
trimetrexate glucuronate	Neutrexin
bacitracin, micronized	bacitracin, micronized (bulk)
colistin sulfate	colistin sulfate (bulk)
gentian violet	gentian violet (bulk)
cephalexin	cephalexin (bulk)
cefadroxil	cefadroxil hydrate (bulk)
demeclocycline HCl	demeclocycline HCl (bulk)
cefaclor	cefaclor (bulk)
ceftriaxone sodium	ceftriaxone sodium (bulk)
idoxuridine	idoxuridine (bulk)
vidarabine	vidarabine (bulk)
ticarcillin disodium/potassium clavulanate	ticarcillin-K clavulanat(bulk)
oseltamivir phosphate	oseltamivir phosphate (bulk)
amoxicillin	Trimox 250
delafloxacin meglumine	Baxdela
meropenem/vaborbactam	Vabomere
oritavancin diphosphate	Kimyrsa
rezafungin acetate	Rezzayo
ivermectin	Stromectol
thiabendazole	Mintezol
elbasvir/grazoprevir	Zepatier
letermovir	Prevymis
raltegravir potassium	Isentress HD
cefoxitin sodium	Mefoxin
imipenem/cilastatin sodium	Primaxin IV
imipenem/cilastatin sodium	Primaxin IM
caspofungin acetate	Cancidas
ertapenem sodium	Invanz

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

Generic Name	Brand Name
imipenem/cilastatin sodium/relebactam	Recarbrio
doravirine/lamivudine/tenofovir disoproxil fumarate	Delstrigo
boceprevir	Victrelis
ribavirin	Rebetol
peginterferon alfa-2b	PegIntron
peginterferon alfa-2b	PegIntron Redipen
posaconazole	Noxafil
ciprofloxacin lactate	Cipro I.V.
fidaxomicin	Dificid
daptomycin	Cubicin
daptomycin	Cubicin RF
ceftolozane sulfate/tazobactam sodium	Zerbaxa
tedizolid phosphate	Sivextro
itraconazole	Onmel
cefditoren pivoxil	cefditoren pivoxil
methenamine/sod phosph,monobasic/methylene blue/hyoscyamine	methen-sod phos-meth blue-hyos
methenamine/sod phosph,monobasic/methylene blue/hyoscyamine	Uro-Blue
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uro-MP
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uro-L
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uro-458
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uribel
methenamine/methylene blue/benzoic acid/salicylat/hyoscyamin	Uribel Tabs
trimethoprim	Proloprim
sulfamethoxazole/trimethoprim	Septra I.V.
sulfamethoxazole/trimethoprim	Septra DS
penicillin G procaine	penicillin G procaine
chloramphenicol sod succinate	Chloromycetin
dirithromycin	Dynabac
oteseconazole	Vivjoa
fosamprenavir calcium	fosamprenavir
moxifloxacin HCl in sodium chloride, iso-osmotic	moxifloxacin-sod.chloride(iso)
efavirenz/lamivudine/tenofovir disoproxil fumarate	Symfi Lo
lamivudine/tenofovir disoproxil fumarate	Cimduo
efavirenz/lamivudine/tenofovir disoproxil fumarate	Symfi
pretomanid	pretomanid
lefamulin acetate	Xenleta
clofazimine	Lamprene
telbivudine	Tyzeka
triclabendazole	Egaten
methenamine/benzoic acid/salicylate/salicylamide	Cystex (methenamine-benz acid)
doxycycline monohydrate	Mondoxyne NL

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

Generic Name	Brand Name
doxycycline hyclate	Soloxide
ofloxacin/dextrose 5 % in water	Floxin I.V. in D5W
doripenem	Doribax
praziquantel	praziquantel
tetracycline HCl	Sumycin 250
tetracycline HCl	Sumycin 500
colistin (as colistimethate sodium)	Coly-Mycin M Parenteral
omadacycline tosylate	Nuzyra
omadacycline tosylate	Nuzyra (7 Day)
omadacycline tosylate	Nuzyra (7 Day with Load Dose)
doxycycline hyclate	Vibramycin
penicillin V potassium	Pen-Vee K
chloroquine phosphate	Aralen Phosphate
cefaclor	Raniclor
vancomycin HCl in sterile water	vancomycin HCl in water
penicillin G potassium	Pfizerpen-G
voriconazole	Vfend IV
piperacillin sodium/tazobactam sodium	Zosyn
anidulafungin	Eraxis(Water Diluent)
carbenicillin indanyl sodium	Geocillin
nirmatrelvir/ritonavir	Paxlovid
clindamycin phosphate	Cleocin
amphotericin B	Amphocin
ampicillin sodium/sulbactam sodium	Unasyn
anidulafungin	Eraxis (Alcohol Diluent)
penicillin G benzathine	Permapen
bacampicillin HCl	Spectrobid
oxytetracycline/lidocaine	Terramycin (with lidocaine)
oxytetracycline HCl/sulfamethizole/phenazopyridine	Urobiotic
cefoperazone sodium	Cefobid
troleandomycin	Tao
fluconazole in sodium chloride, iso-osmotic	Diflucan in NaCl (iso-osm)
fluconazole in dextrose, iso-osmotic	Diflucan in dextrose (iso-osm)
ceftazidime	ceftazidime
oxytetracycline HCl	Terramycin
doxycycline monohydrate	Vibramycin (mono)
doxycycline calcium	Vibramycin (calcium)
doxycycline hyclate	Vibra-Tabs
azithromycin	Zmax Pediatric
clindamycin phosphate/dextrose 5 % in water	Cleocin in 5 % dextrose
clindamycin palmitate HCl	Cleocin Pediatric
lomefloxacin HCl	Maxaquin
doxycycline monohydrate/skin cleanser combination no.9	Adoxa TT
doxycycline monohydrate/skin cleanser combination no.9	Adoxa CK
sulfisoxazole/phenazopyridine HCl	Azo-Gantrisin
rimantadine HCl/dietary supplement,misc comb14	Rimantalist
rifampin	Rimactane

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

Generic Name	Brand Name
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	UTA (with phenyl salicylate)
telithromycin	Ketek
methenamine/sod phosph,monobasic/methylene blue/hyoscyamine	Uryl
amoxicillin	Moxatag
acyclovir/benzyl alcohol	Acyclovix
gramicidin D	gramicidin D (bulk)
bacitracin zinc micronized	bacitracin Zn micronized(bulk)
betanaphthol	betanaphthol (bulk)
octanoic acid	octanoic acid (bulk)
sulfacetamide	sulfacetamide (bulk)
quinine HCl dihydrate	quinine HCl dihydrate (bulk)
aminosalicylic acid	aminosalicylic acid (bulk)
diethylcarbamazine citrate	diethylcarbamazine cit (bulk)
niclosamide	niclosamide (bulk)
furazolidone	furazolidone (bulk)
erythromycin estolate	erythromycin estolate (bulk)
clofazimine	clofazimine (bulk)
aminosalicylate sodium	aminosalicylate sodium (bulk)
phenoxyethanol	phenoxyethanol (bulk)
acetarsol	acetarsol (bulk)
cycloserine	cycloserine (bulk)
paromomycin sulfate	paromomycin sulfate (bulk)
antimony trisulfide colloid	antimony trisulfide (bulk)
pyrazinamide	pyrazinamide (bulk)
famciclovir	famciclovir (bulk)
miltefosine	Impavido
penicillin G benzathine	Extencilline
ribavirin	RIBATAB
ribavirin	RIBATAB Dose Pack
sulfisoxazole/phenazopyridine HCl	sulfisoxazole-phenazopyridine
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uroblue
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uro Blue
amoxicillin	DisperMox
cephalexin	Panixine DisperDose
pyrantel pamoate	Reese's Pinworm Medicine
methenamine/sodium salicylate	URO-PAIN Dual Action
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Darpaz
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Darcalma
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Phosenamine
methenamine/methylene blue/benzoic acid/salicylat/hyoscyamin	Methylphen

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

Generic Name	Brand Name
sulfamethoxazole	Gantanol
pyrimethamine/sulfadoxine	Fansidar
amphotericin B	Fungizone
isoniazid	Nydrazid
amoxicillin	Trimox 125
doxycycline monohydrate	Adoxa Pak
nalidixic acid	NegGram
enoxacin	Penetrex
rifampin/isoniazid/pyrazinamide	Rifater
rifapentine	Priftin
methenamine hippurate	Hiprex
acyclovir sodium/dextrose 5 % in water	acyclovir sod in dextrose 5 %
gentamicin sulfate	Garamycin
netilmicin sulfate	Netromycin
ribavirin/interferon alfa-2b,recomb.	Rebetron 1200/MDV
ribavirin/interferon alfa-2b,recomb.	Rebetron 1000/MDV
ribavirin/interferon alfa-2b,recomb.	Rebetron 600/MDV
ribavirin/interferon alfa-2b,recomb.	Rebetron 1200/Pak-3
ribavirin/interferon alfa-2b,recomb.	Rebetron 1000/Pak-3
ribavirin/interferon alfa-2b,recomb.	Rebetron 600/Pak-3
ribavirin/interferon alfa-2b,recomb.	Rebetron 1200/3 MIU Pen
ribavirin/interferon alfa-2b,recomb.	Rebetron 1000/3 MIU Pen
ribavirin/interferon alfa-2b,recomb.	Rebetron 600/3 MIU Pen
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Urneva
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Uro-SP
metronidazole in sodium chloride	Flagyl RTU
ibrexafungerp citrate	Brexafemme
Methenamine/Methylene Blue/Benzoic/Phenyl Sal/Atropin/Hyoscy	Uriseptic
erythromycin stearate	My-E
cefiderocol sulfate tosylate	Fetroja
furazolidone	Furoxone
azithromycin hydrogen citrate	azithromycin hydrogen citrate
tecovirimat	Tpoxx (National Stockpile)
methenamine/sod phosph,monobasic/methylene blue/hyoscyamine	UTA
penicillin V potassium	Beepen VK
penicillin V potassium	Beepen-VK
ampicillin trihydrate	Totacillin
sulfamethoxazole/trimethoprim	SMZ-TMP DS
calcium propionate	calcium propionate (bulk)
piperazine citrate	piperazine citrate (bulk)
foscarnet sodium	foscarnet (bulk)
maribavir	Livtencity
eravacycline di-hydrochloride	Xerava
ibalizumab-uiyk	Trogarzo

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

Generic Name	Brand Name
tetracycline HCl	Brodspec
ampicillin trihydrate	Amficot
erythromycin stearate	Erythrocot
doxycycline hyclate	Bio-Tab
methenamine hippurate	Urex (methenamine)
telaprevir	Incivek
cabotegravir	cabotegravir
cabotegravir	Apretude
cabotegravir/rilpivirine	Cabenuva
dolutegravir sodium/rilpivirine HCl	Juluca
rilpivirine	rilpivirine
dolutegravir sodium/lamivudine	Dovato
cabotegravir sodium	Vocabria
fostemsavir tromethamine	Rukobia
dolutegravir sodium	Tivicay PD
abacavir sulfate/dolutegravir sodium/lamivudine	Triumeq PD
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Vilevev MB
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	Vilamit MB
methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine	UriSym
methenamine mandelate/sodium phosphate,monobasic	Visqid A/A
cinoxacin	Cinobac
methenamine mandelate	Mandelamine
tigecycline	Tygacil
piperacillin sodium	Pipracil
bacitracin	BACiiM
neomycin sulfate	Neo-Fradin
streptomycin sulfate	streptomycin
erythromycin base	Erythro-Rx
nystatin	Nystat-Rx
vancomycin HCl in water for injection (PEG-400, NADA)	vancomycin-diluent combo no.1
berberine chloride	berberine chloride
dihydroberberine	Berberine ES-5
Filgrastim Injections	
filgrastim	Neupogen
pegfilgrastim	Neulasta
pegfilgrastim	Neulasta Onpro
filgrastim-ayow	Releuko
pegfilgrastim-pbbk	Fylnetra
pegfilgrastim-jmdb	Fulphila
tbo-filgrastim	Granix
pegfilgrastim-cbqv	Udenyca
pegfilgrastim-cbqv	Udenyca Autoinjector
pegfilgrastim-cbqv	Udenyca Onbody
pegfilgrastim-fpgk	Stimufend
filgrastim-aafi	Nivestym

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

Generic Name	Brand Name
pegfilgrastim-apgf	Nyvepria
filgrastim-sndz	Zarxio
pegfilgrastim-bmez	Ziextenzo
Substance Use Disorder	
buprenorphine HCl	buprenorphine HCl
buprenorphine HCl/naloxone HCl	buprenorphine-naloxone
buprenorphine	Sublocade
buprenorphine HCl/naloxone HCl	Suboxone
buprenorphine HCl	Subutex
buprenorphine HCl	Probuphine
buprenorphine HCl/naloxone HCl	Zubsolv
buprenorphine HCl/naloxone HCl	Bunavail
Chemotherapy	
selpercatinib	Retevmo
abemaciclib	Verzenio
pemetrexed disodium	Alimta
ramucirumab	Cyramza
necitumumab	Portrazza
dasatinib	Sprycel
hydroxyurea	Hydrea
elotuzumab	Empliciti
ipilimumab	Yervoy
nivolumab	Opdivo
capecitabine	Xeloda
vorinostat	Zolinza
pembrolizumab	Keytruda
trastuzumab-dttb	Ontruzant
inotuzumab ozogamicin	Besponsa
temsirolimus	Torisel
gemtuzumab ozogamicin	Mylotarg
epirubicin HCl	Ellence
irinotecan HCl	Camptosar
idarubicin HCl	Idamycin PFS
carmustine	BiCNU
isatuximab-irfc	Sarclisa
cabazitaxel	Jevtana
ziv-aflibercept	Zaltrap
clofarabine	Clolar
imatinib mesylate	imatinib
capecitabine	capecitabine
cyclophosphamide	cyclophosphamide
bexarotene	bexarotene
everolimus	everolimus (antineoplastic)
methotrexate sodium	methotrexate sodium
mercaptopurine	mercaptopurine
bosutinib	Bosulif
axitinib	Inlyta
palbociclib	Ibrance

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

Generic Name	Brand Name
dacomitinib	Vizimpro
lorlatinib	Lorbrena
rituximab-pvvr	Ruxience
talazoparib tosylate	Talzenna
glasdegib maleate	Daurismo
trastuzumab-qyyp	Trazimera
bevacizumab-bvzr	Zirabev
sunitinib malate	Sutent
doxorubicin HCl	doxorubicin
crizotinib	Xalkori
venetoclax	Venclexta
venetoclax	Venclexta Starting Pack
imatinib mesylate	Gleevec
nilotinib HCl	Tasigna
everolimus	Afinitor
everolimus	Afinitor Disperz
sonidegib phosphate	Odomzo
panobinostat lactate	Farydak
ofatumumab	Arzerra
lapatinib ditosylate	Tykerb
topotecan HCl	Hycamtin
dabrafenib mesylate	Tafinlar
nelarabine	Arranon
ceritinib	Zykadia
midostaurin	Rydapt
alpelisib	Piqray
capmatinib hydrochloride	Tabrecta
tisagenlecleucel	Kymriah
ribociclib succinate	Kisqali
ribociclib succinate/letrozole	Kisqali Femara Co-Pack
temozolomide	Temodar
erlotinib HCl	erlotinib
idarubicin HCl	idarubicin
bleomycin sulfate	bleomycin
dacarbazine	dacarbazine
doxorubicin HCl	Adriamycin
mitomycin	mitomycin
thiotepa	thiotepa
methotrexate sodium/PF	methotrexate sodium (PF)
etoposide	etoposide
cisplatin	cisplatin
ifosfamide	ifosfamide
daunorubicin HCl	daunorubicin
irinotecan HCl	irinotecan
azacitidine	azacitidine
cladribine	cladribine
belantamab mafodotin-blmf	Blenrep
bexarotene	Targretin

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

Generic Name	Brand Name
gefitinib	Iressa
selumetinib sulfate/vitamin E TPGS	Koselugo
olaparib	Lynparza
osimertinib mesylate	Tagrisso
durvalumab	Imfinzi
moxetumomab pasudotox-tdfk	Lumoxiti
doxorubicin HCl pegylated liposomal	Doxil
ifosfamide	Ifex
gemcitabine HCl	gemcitabine
docetaxel	docetaxel
topotecan HCl	topotecan
pentostatin	Nipent
busulfan	busulfan
gilteritinib fumarate	Xospata
hydroxyurea	hydroxyurea
afatinib dimaleate	Gilotrif
fluorouracil	Adrucil
paclitaxel	paclitaxel
oxaliplatin	oxaliplatin
romidepsin	romidepsin
carboplatin	carboplatin
vincristine sulfate	Vincasar PFS
streptozocin	Zanosar
clofarabine	clofarabine
arsenic trioxide	arsenic trioxide
irinotecan liposomal	Onivyde
doxorubicin HCl pegylated liposomal	doxorubicin, peg-liposomal
temozolomide	temozolomide
temsirolimus	temsirolimus
decitabine	decitabine
fluorouracil	fluorouracil
carmustine	carmustine
valrubicin	valrubicin
fludarabine phosphate	fludarabine
carmustine in polifeprosan 20	Gliadel Wafer
vinorelbine tartrate	vinorelbine
sipuleucel-T/lactated ringers solution	Provenge
dactinomycin	dactinomycin
bendamustine HCl	bendamustine
bendamustine HCl	Belrapzo
cabozantinib s-malate	Cometriq
cabozantinib s-malate	Cabometyx
mogamulizumab-kpkc	Poteligeo
melphalan HCl	melphalan HCl
bortezomib	bortezomib
avelumab	Bavencio
tepotinib HCl	Tepmetko
teniposide	teniposide

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

Generic Name	Brand Name
melphalan	melphalan
pralatrexate	Folotyn
rituximab	Rituxan
bevacizumab	Avastin
erlotinib HCl	Tarceva
obinutuzumab	Gazyva
trastuzumab-hyaluronidase-oysk	Herceptin Hylecta
ado-trastuzumab emtansine	Kadcyla
vemurafenib	Zelboraf
entrectinib	Rozlytrek
polatuzumab vedotin-piiq	Polivy
rituximab/hyaluronidase, human recombinant	Rituxan Hycela
alectinib HCl	Alecensa
trastuzumab	Herceptin
vismodegib	Erivedge
pertuzumab	Perjeta
pertuzumab-trastuzumab-hyaluronidase-zzxf	Phesgo
cobimetinib fumarate	Cotellic
atezolizumab	Tecentriq
regorafenib	Stivarga
copanlisib di-HCl	Aliqopa
larotrectinib sulfate	Vitrakvi
sorafenib tosylate	Nexavar
glucarpidase	Voraxaze
ruxolitinib phosphate	Jakafi
pemigatinib	Pemazyre
tucatinib	Tukysa
enfortumab vedotin-ejfv	Padcev
brentuximab vedotin	Adcetris
methotrexate sodium	Trexall
melphalan	Alkeran
melphalan HCl	Alkeran (as HCl)
methotrexate	Xatmep
methotrexate/PF	Otrexup (PF)
procarbazine HCl	Matulane
sacituzumab govitecan-hziy	Trodelvy
dactinomycin	Cosmegen
talimogene laherparepvec	Imlygic
trastuzumab-anns	Kanjinti
blinatumomab	Blincyto
bevacizumab-awwb	Mvasi
rituximab-arrx	Riabni
panitumumab	Vectibix
daratumumab	Darzalex
daratumumab-hyaluronidase-fihj	Darzalex Faspro
ibrutinib	Imbruvica
lomustine	Gleostine
alemtuzumab	Lemtrada

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

Generic Name	Brand Name
alemtuzumab	Campath
vandetanib	Caprelsa
methotrexate/PF	Rasuvo (PF)
busulfan	Busulfex
azacitidine	Vidaza
pomalidomide	Pomalyst
enasidenib mesylate	Idhifa
fedratinib dihydrochloride	Inrebic
romidepsin	Istodax
erdafitinib	Balversa
trabectedin	Yondelis
epirubicin HCl	epirubicin
etoposide phosphate	Etopophos
cytarabine/PF	cytarabine (PF)
cytarabine	cytarabine
vincristine sulfate	vincristine
mitoxantrone HCl	mitoxantrone
cemiplimab-rwlc	Libtayo
idelalisib	Zydelig
mercaptopurine	Purixan
gemcitabine HCl in 0.9 % sodium chloride	Infugem
eribulin mesylate	Halaven
decitabine	Dacogen
lenvatinib mesylate	Lenvima
bortezomib	Velcade
brigatinib	Alunbrig
ixazomib citrate	Ninlaro
ponatinib HCl	Iclusig
floxuridine	floxuridine
vinblastine sulfate	vinblastine
rituximab-abbs	Truxima
omacetaxine mepesuccinate	Synribo
trastuzumab-pkrb	Herzuma
bendamustine HCl	Bendeka
bendamustine HCl	Treanda
arsenic trioxide	Trisenox
decitabine/cedazuridine	Inqovi
trifluridine/tipiracil HCl	Lonsurf
fam-trastuzumab deruxtecan-nxki	Enhertu
dinutuximab	Unituxin
cetuximab	Erbitux
valrubicin	Valstar
lapatinib ditosylate	lapatinib
lurbinectedin	Zepzelca
daunorubicin/cytarabine liposomal	Vyxeos
paclitaxel protein-bound	Abraxane
mitomycin	Mutamycin
carboplatin	Paraplatin

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

Generic Name	Brand Name
rucaparib camsylate	Rubraca
ixabepilone	Ixempra
thiotepa	Tepadina
binimetinib	Mektovi
encorafenib	Braftovi
neratinib maleate	Nerlynx
axicabtagene ciloleucel	Yescarta
brexucabtagene autoleucel	Tecartus
fostamatinib disodium	Tavalisse
duvelisib	Copiktra
avapritinib	Ayvakit
tagraxofusp-erzs	Elzonris
selinexor	Xpovio
zanubrutinib	Brukinsa
tazemetostat hydrobromide	Tazverik
calaspargase pegol-mknl	Asparlas
pegaspargase	Oncaspar
melphalan HCl/betadex sulfobutyl ether sodium	Evomela
belinostat	Beleodaq
kit for prep yttrium-90/ibritumomab tiuxetan/albumin human	Zevalin (Y-90)
vincristine sulfate liposomal	Marqibo
naxitamab-gqgk	Danyelza
lisocabtagene maraleucel	Breyanzi
ripretinib	Qinlock
trilaciclib dihydrochloride	Cosela
tafasitamab-cxix	Monjuvi
carfilzomib	Kyprolis
aldesleukin	Proleukin
trastuzumab-dkst	Ogivri
niraparib tosylate	Zejula
etoposide	Toposar
pexidartinib hydrochloride	Turalio
acalabrutinib	Calquence
trametinib dimethyl sulfoxide	Mekinist
docetaxel	Docefrez

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
	Anxiety		
F06.4	Anxiety disorder due to known physiological condition	ICD-10-CM	Diagnosis
F40.00	Agoraphobia, unspecified	ICD-10-CM	Diagnosis
F40.01	Agoraphobia with panic disorder	ICD-10-CM	Diagnosis
F40.02	Agoraphobia without panic disorder	ICD-10-CM	Diagnosis
F40.10	Social phobia, unspecified	ICD-10-CM	Diagnosis
F40.11	Social phobia, generalized	ICD-10-CM	Diagnosis
F40.210	Arachnophobia	ICD-10-CM	Diagnosis
F40.218	Other animal type phobia	ICD-10-CM	Diagnosis
F40.220	Fear of thunderstorms	ICD-10-CM	Diagnosis
F40.228	Other natural environment type phobia	ICD-10-CM	Diagnosis
F40.230	Fear of blood	ICD-10-CM	Diagnosis
F40.231	Fear of injections and transfusions	ICD-10-CM	Diagnosis
F40.232	Fear of other medical care	ICD-10-CM	Diagnosis
F40.233	Fear of injury	ICD-10-CM	Diagnosis
F40.240	Claustrophobia	ICD-10-CM	Diagnosis
F40.241	Acrophobia	ICD-10-CM	Diagnosis
F40.242	Fear of bridges	ICD-10-CM	Diagnosis
F40.243	Fear of flying	ICD-10-CM	Diagnosis
F40.248	Other situational type phobia	ICD-10-CM	Diagnosis
F40.290	Androphobia	ICD-10-CM	Diagnosis
F40.291	Gynephobia	ICD-10-CM	Diagnosis
F40.298	Other specified phobia	ICD-10-CM	Diagnosis
F40.8	Other phobic anxiety disorders	ICD-10-CM	Diagnosis
F40.9	Phobic anxiety disorder, unspecified	ICD-10-CM	Diagnosis
F41.0	Panic disorder [episodic paroxysmal anxiety]	ICD-10-CM	Diagnosis
F41.1	Generalized anxiety disorder	ICD-10-CM	Diagnosis
F41.3	Other mixed anxiety disorders	ICD-10-CM	Diagnosis
F41.8	Other specified anxiety disorders	ICD-10-CM	Diagnosis
F41.9	Anxiety disorder, unspecified	ICD-10-CM	Diagnosis
F42.2	Mixed obsessional thoughts and acts	ICD-10-CM	Diagnosis
F42.3	Hoarding disorder	ICD-10-CM	Diagnosis
F42.4	Excoriation (skin-picking) disorder	ICD-10-CM	Diagnosis
F42.8	Other obsessive-compulsive disorder	ICD-10-CM	Diagnosis
F42.9	Obsessive-compulsive disorder, unspecified	ICD-10-CM	Diagnosis
F43.0	Acute stress reaction	ICD-10-CM	Diagnosis
F44.9	Dissociative and conversion disorder, unspecified	ICD-10-CM	Diagnosis
F45.8	Other somatoform disorders	ICD-10-CM	Diagnosis
R45.7	State of emotional shock and stress, unspecified	ICD-10-CM	Diagnosis
313.83	Academic underachievement disorder of childhood or adolescence	ICD-9-CM	Diagnosis
300.21	Agoraphobia with panic disorder	ICD-9-CM	Diagnosis
300.22	Agoraphobia without mention of panic attacks	ICD-9-CM	Diagnosis
293.84	Anxiety disorder in conditions classified elsewhere	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
300.00	Anxiety state, unspecified	ICD-9-CM	Diagnosis
300.02	Generalized anxiety disorder	ICD-9-CM	Diagnosis
300.10	Hysteria, unspecified	ICD-9-CM	Diagnosis
313.82	Identity disorder of childhood or adolescence	ICD-9-CM	Diagnosis
313.22	Introverted disorder of childhood	ICD-9-CM	Diagnosis
313.1	Misery and unhappiness disorder specific to childhood and adolescence	ICD-9-CM	Diagnosis
308.4	Mixed disorders as reaction to stress	ICD-9-CM	Diagnosis
300.5	Neurasthenia	ICD-9-CM	Diagnosis
300.3	Obsessive-compulsive disorders	ICD-9-CM	Diagnosis
308.3	Other acute reactions to stress	ICD-9-CM	Diagnosis
300.09	Other anxiety states	ICD-9-CM	Diagnosis
300.29	Other isolated or specific phobias	ICD-9-CM	Diagnosis
300.89	Other somatoform disorders	ICD-9-CM	Diagnosis
313.0	Overanxious disorder specific to childhood and adolescence	ICD-9-CM	Diagnosis
300.01	Panic disorder without agoraphobia	ICD-9-CM	Diagnosis
300.20	Phobia, unspecified	ICD-9-CM	Diagnosis
309.81	Posttraumatic stress disorder	ICD-9-CM	Diagnosis
308.1	Predominant disturbance of consciousness as reaction to stress	ICD-9-CM	Diagnosis
308.2	Predominant psychomotor disturbance as reaction to stress	ICD-9-CM	Diagnosis
308.0	Predominant disturbance of emotions	ICD-9-CM	Diagnosis
313.3	Relationship problems specific to childhood and adolescence	ICD-9-CM	Diagnosis
313.21	Shyness disorder of childhood	ICD-9-CM	Diagnosis
300.23	Social phobia	ICD-9-CM	Diagnosis
308.9	Unspecified acute reaction to stress	ICD-9-CM	Diagnosis
300.9	Unspecified nonpsychotic mental disorder	ICD-9-CM	Diagnosis
	Bipolar Disorder		
296.00	Bipolar I disorder, single manic episode, unspecified	ICD-9-CM	Diagnosis
296.01	Bipolar I disorder, single manic episode, mild	ICD-9-CM	Diagnosis
296.02	Bipolar I disorder, single manic episode, moderate	ICD-9-CM	Diagnosis
296.03	Bipolar I disorder, single manic episode, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.04	Bipolar I disorder, single manic episode, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.05	Bipolar I disorder, single manic episode, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.06	Bipolar I disorder, single manic episode, in full remission	ICD-9-CM	Diagnosis
296.10	Manic disorder, recurrent episode, unspecified	ICD-9-CM	Diagnosis
296.11	Manic disorder, recurrent episode, mild	ICD-9-CM	Diagnosis
296.12	Manic disorder, recurrent episode, moderate	ICD-9-CM	Diagnosis
296.13	Manic disorder, recurrent episode, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
296.14	Manic disorder, recurrent episode, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.15	Manic disorder, recurrent episode, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.16	Manic disorder, recurrent episode, in full remission	ICD-9-CM	Diagnosis
296.40	Bipolar I disorder, most recent episode (or current) manic, unspecified	ICD-9-CM	Diagnosis
296.41	Bipolar I disorder, most recent episode (or current) manic, mild	ICD-9-CM	Diagnosis
296.42	Bipolar I disorder, most recent episode (or current) manic, moderate	ICD-9-CM	Diagnosis
296.43	Bipolar I disorder, most recent episode (or current) manic, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.44	Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.45	Bipolar I disorder, most recent episode (or current) manic, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.46	Bipolar I disorder, most recent episode (or current) manic, in full remission	ICD-9-CM	Diagnosis
296.50	Bipolar I disorder, most recent episode (or current) depressed, unspecified	ICD-9-CM	Diagnosis
296.51	Bipolar I disorder, most recent episode (or current) depressed, mild	ICD-9-CM	Diagnosis
296.52	Bipolar I disorder, most recent episode (or current) depressed, moderate	ICD-9-CM	Diagnosis
296.53	Bipolar I disorder, most recent episode (or current) depressed, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.54	Bipolar I disorder, most recent episode (or current) depressed, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.55	Bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.56	Bipolar I disorder, most recent episode (or current) depressed, in full remission	ICD-9-CM	Diagnosis
296.60	Bipolar I disorder, most recent episode (or current) mixed, unspecified	ICD-9-CM	Diagnosis
296.61	Bipolar I disorder, most recent episode (or current) mixed, mild	ICD-9-CM	Diagnosis
296.62	Bipolar I disorder, most recent episode (or current) mixed, moderate	ICD-9-CM	Diagnosis
296.63	Bipolar I disorder, most recent episode (or current) mixed, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.64	Bipolar I disorder, most recent episode (or current) mixed, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.65	Bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified remission	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
296.66	Bipolar I disorder, most recent episode (or current) mixed, in full remission	ICD-9-CM	Diagnosis
296.7	Bipolar I disorder, most recent episode (or current) unspecified	ICD-9-CM	Diagnosis
296.80	Bipolar disorder, unspecified	ICD-9-CM	Diagnosis
296.81	Atypical manic disorder	ICD-9-CM	Diagnosis
296.82	Atypical depressive disorder	ICD-9-CM	Diagnosis
296.89	Other and unspecified bipolar disorders	ICD-9-CM	Diagnosis
296.90	Unspecified episodic mood disorder	ICD-9-CM	Diagnosis
296.99	Other specified episodic mood disorder	ICD-9-CM	Diagnosis
F30.10	Manic episode without psychotic symptoms, unspecified	ICD-10-CM	Diagnosis
F30.11	Manic episode without psychotic symptoms, mild	ICD-10-CM	Diagnosis
F30.12	Manic episode without psychotic symptoms, moderate	ICD-10-CM	Diagnosis
F30.13	Manic episode, severe, without psychotic symptoms	ICD-10-CM	Diagnosis
F30.2	Manic episode, severe with psychotic symptoms	ICD-10-CM	Diagnosis
F30.3	Manic episode in partial remission	ICD-10-CM	Diagnosis
F30.4	Manic episode in full remission	ICD-10-CM	Diagnosis
F30.8	Other manic episodes	ICD-10-CM	Diagnosis
F30.9	Manic episode, unspecified	ICD-10-CM	Diagnosis
F31.0	Bipolar disorder, current episode hypomanic	ICD-10-CM	Diagnosis
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified	ICD-10-CM	Diagnosis
F31.11	Bipolar disorder, current episode manic without psychotic features, mild	ICD-10-CM	Diagnosis
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate	ICD-10-CM	Diagnosis
F31.13	Bipolar disorder, current episode manic without psychotic features, severe	ICD-10-CM	Diagnosis
F31.2	Bipolar disorder, current episode manic severe with psychotic features	ICD-10-CM	Diagnosis
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified	ICD-10-CM	Diagnosis
F31.31	Bipolar disorder, current episode depressed, mild	ICD-10-CM	Diagnosis
F31.32	Bipolar disorder, current episode depressed, moderate	ICD-10-CM	Diagnosis
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features	ICD-10-CM	Diagnosis
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features	ICD-10-CM	Diagnosis
F31.60	Bipolar disorder, current episode mixed, unspecified	ICD-10-CM	Diagnosis
F31.61	Bipolar disorder, current episode mixed, mild	ICD-10-CM	Diagnosis
F31.62	Bipolar disorder, current episode mixed, moderate	ICD-10-CM	Diagnosis
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features	ICD-10-CM	Diagnosis
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified	ICD-10-CM	Diagnosis
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic	ICD-10-CM	Diagnosis
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic	ICD-10-CM	Diagnosis
F31.73	Bipolar disorder, in partial remission, most recent episode manic	ICD-10-CM	Diagnosis
F31.74	Bipolar disorder, in full remission, most recent episode manic	ICD-10-CM	Diagnosis
F31.75	Bipolar disorder, in partial remission, most recent episode depressed	ICD-10-CM	Diagnosis
F31.76	Bipolar disorder, in full remission, most recent episode depressed	ICD-10-CM	Diagnosis
F31.77	Bipolar disorder, in partial remission, most recent episode mixed	ICD-10-CM	Diagnosis
F31.78	Bipolar disorder, in full remission, most recent episode mixed	ICD-10-CM	Diagnosis
F31.81	Bipolar II disorder	ICD-10-CM	Diagnosis
F31.89	Other bipolar disorder	ICD-10-CM	Diagnosis
F31.9	Bipolar disorder, unspecified	ICD-10-CM	Diagnosis
F33.8	Other recurrent depressive disorders	ICD-10-CM	Diagnosis
F34.81	Disruptive mood dysregulation disorder	ICD-10-CM	Diagnosis
F34.89	Other specified persistent mood disorders	ICD-10-CM	Diagnosis
F34.9	Persistent mood [affective] disorder, unspecified	ICD-10-CM	Diagnosis
F39	Unspecified mood [affective] disorder	ICD-10-CM	Diagnosis
	Cardiovascular Disease		
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall	ICD-10-CM	Diagnosis
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall	ICD-10-CM	Diagnosis
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery	ICD-10-CM	Diagnosis
I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery	ICD-10-CM	Diagnosis
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall	ICD-10-CM	Diagnosis
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall	ICD-10-CM	Diagnosis
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery	ICD-10-CM	Diagnosis
I21.29	ST elevation (STEMI) myocardial infarction involving other sites	ICD-10-CM	Diagnosis
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites	ICD-10-CM	Diagnosis
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	ICD-10-CM	Diagnosis
I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery	ICD-10-CM	Diagnosis
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site	ICD-10-CM	Diagnosis
I21.9	Acute myocardial infarction, unspecified	ICD-10-CM	Diagnosis
I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site	ICD-10-CM	Diagnosis
I21	Acute myocardial infarction	ICD-10-CM	Diagnosis
I21.0	ST elevation (STEMI) myocardial infarction of anterior wall	ICD-10-CM	Diagnosis
I21.1	ST elevation (STEMI) myocardial infarction of inferior wall	ICD-10-CM	Diagnosis
I21.2	ST elevation (STEMI) myocardial infarction of other sites	ICD-10-CM	Diagnosis
I22	Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction	ICD-10-CM	Diagnosis
I21.A1	Myocardial infarction Type 2	ICD-10-CM	Diagnosis
I21.A9	Other myocardial infarction type	ICD-10-CM	Diagnosis
I21.A	Other type of myocardial infarction	ICD-10-CM	Diagnosis
I63.22	Cerebral infarction due to unspecified occlusion or stenosis of basilar artery	ICD-10-CM	Diagnosis
I63.139	Cerebral infarction due to embolism of unspecified carotid artery	ICD-10-CM	Diagnosis
I63.239	Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid artery	ICD-10-CM	Diagnosis
I63.019	Cerebral infarction due to thrombosis of unspecified vertebral artery	ICD-10-CM	Diagnosis
I63.119	Cerebral infarction due to embolism of unspecified vertebral artery	ICD-10-CM	Diagnosis
I63.219	Cerebral infarction due to unspecified occlusion or stenosis of unspecified vertebral artery	ICD-10-CM	Diagnosis
I63.59	Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery	ICD-10-CM	Diagnosis
I63.20	Cerebral infarction due to unspecified occlusion or stenosis of unspecified precerebral arteries	ICD-10-CM	Diagnosis
I63.30	Cerebral infarction due to thrombosis of unspecified cerebral artery	ICD-10-CM	Diagnosis
I63.40	Cerebral infarction due to embolism of unspecified cerebral artery	ICD-10-CM	Diagnosis
I63.50	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery	ICD-10-CM	Diagnosis
I63.02	Cerebral infarction due to thrombosis of basilar artery	ICD-10-CM	Diagnosis
I63.12	Cerebral infarction due to embolism of basilar artery	ICD-10-CM	Diagnosis
I63.031	Cerebral infarction due to thrombosis of right carotid artery	ICD-10-CM	Diagnosis
I63.032	Cerebral infarction due to thrombosis of left carotid artery	ICD-10-CM	Diagnosis
I63.033	Cerebral infarction due to thrombosis of bilateral carotid arteries	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I63.039	Cerebral infarction due to thrombosis of unspecified carotid artery	ICD-10-CM	Diagnosis
I63.131	Cerebral infarction due to embolism of right carotid artery	ICD-10-CM	Diagnosis
I63.132	Cerebral infarction due to embolism of left carotid artery	ICD-10-CM	Diagnosis
I63.133	Cerebral infarction due to embolism of bilateral carotid arteries	ICD-10-CM	Diagnosis
I63.231	Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries	ICD-10-CM	Diagnosis
I63.232	Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries	ICD-10-CM	Diagnosis
I63.233	Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries	ICD-10-CM	Diagnosis
I63.011	Cerebral infarction due to thrombosis of right vertebral artery	ICD-10-CM	Diagnosis
I63.012	Cerebral infarction due to thrombosis of left vertebral artery	ICD-10-CM	Diagnosis
I63.013	Cerebral infarction due to thrombosis of bilateral vertebral arteries	ICD-10-CM	Diagnosis
I63.111	Cerebral infarction due to embolism of right vertebral artery	ICD-10-CM	Diagnosis
I63.112	Cerebral infarction due to embolism of left vertebral artery	ICD-10-CM	Diagnosis
I63.113	Cerebral infarction due to embolism of bilateral vertebral arteries	ICD-10-CM	Diagnosis
I63.211	Cerebral infarction due to unspecified occlusion or stenosis of right vertebral artery	ICD-10-CM	Diagnosis
I63.212	Cerebral infarction due to unspecified occlusion or stenosis of left vertebral artery	ICD-10-CM	Diagnosis
I63.213	Cerebral infarction due to unspecified occlusion or stenosis of bilateral vertebral arteries	ICD-10-CM	Diagnosis
I63.09	Cerebral infarction due to thrombosis of other precerebral artery	ICD-10-CM	Diagnosis
I63.19	Cerebral infarction due to embolism of other precerebral artery	ICD-10-CM	Diagnosis
I63.00	Cerebral infarction due to thrombosis of unspecified precerebral artery	ICD-10-CM	Diagnosis
I63.10	Cerebral infarction due to embolism of unspecified precerebral artery	ICD-10-CM	Diagnosis
I63.29	Cerebral infarction due to unspecified occlusion or stenosis of other precerebral arteries	ICD-10-CM	Diagnosis
I63.311	Cerebral infarction due to thrombosis of right middle cerebral artery	ICD-10-CM	Diagnosis
I63.312	Cerebral infarction due to thrombosis of left middle cerebral artery	ICD-10-CM	Diagnosis
I63.313	Cerebral infarction due to thrombosis of bilateral middle cerebral arteries	ICD-10-CM	Diagnosis
I63.319	Cerebral infarction due to thrombosis of unspecified middle cerebral artery	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I63.321	Cerebral infarction due to thrombosis of right anterior cerebral artery	ICD-10-CM	Diagnosis
I63.322	Cerebral infarction due to thrombosis of left anterior cerebral artery	ICD-10-CM	Diagnosis
I63.323	Cerebral infarction due to thrombosis of bilateral anterior cerebral arteries	ICD-10-CM	Diagnosis
I63.329	Cerebral infarction due to thrombosis of unspecified anterior cerebral artery	ICD-10-CM	Diagnosis
I63.331	Cerebral infarction due to thrombosis of right posterior cerebral artery	ICD-10-CM	Diagnosis
I63.332	Cerebral infarction due to thrombosis of left posterior cerebral artery	ICD-10-CM	Diagnosis
I63.333	Cerebral infarction due to thrombosis of bilateral posterior cerebral arteries	ICD-10-CM	Diagnosis
I63.339	Cerebral infarction due to thrombosis of unspecified posterior cerebral artery	ICD-10-CM	Diagnosis
I63.341	Cerebral infarction due to thrombosis of right cerebellar artery	ICD-10-CM	Diagnosis
I63.342	Cerebral infarction due to thrombosis of left cerebellar artery	ICD-10-CM	Diagnosis
I63.343	Cerebral infarction due to thrombosis of bilateral cerebellar arteries	ICD-10-CM	Diagnosis
I63.349	Cerebral infarction due to thrombosis of unspecified cerebellar artery	ICD-10-CM	Diagnosis
I63.39	Cerebral infarction due to thrombosis of other cerebral artery	ICD-10-CM	Diagnosis
I63.6	Cerebral infarction due to cerebral venous thrombosis, nonpyogenic	ICD-10-CM	Diagnosis
I63.411	Cerebral infarction due to embolism of right middle cerebral artery	ICD-10-CM	Diagnosis
I63.412	Cerebral infarction due to embolism of left middle cerebral artery	ICD-10-CM	Diagnosis
I63.413	Cerebral infarction due to embolism of bilateral middle cerebral arteries	ICD-10-CM	Diagnosis
I63.419	Cerebral infarction due to embolism of unspecified middle cerebral artery	ICD-10-CM	Diagnosis
I63.421	Cerebral infarction due to embolism of right anterior cerebral artery	ICD-10-CM	Diagnosis
I63.422	Cerebral infarction due to embolism of left anterior cerebral artery	ICD-10-CM	Diagnosis
I63.423	Cerebral infarction due to embolism of bilateral anterior cerebral arteries	ICD-10-CM	Diagnosis
I63.429	Cerebral infarction due to embolism of unspecified anterior cerebral artery	ICD-10-CM	Diagnosis
I63.431	Cerebral infarction due to embolism of right posterior cerebral artery	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I63.432	Cerebral infarction due to embolism of left posterior cerebral artery	ICD-10-CM	Diagnosis
I63.433	Cerebral infarction due to embolism of bilateral posterior cerebral arteries	ICD-10-CM	Diagnosis
I63.439	Cerebral infarction due to embolism of unspecified posterior cerebral artery	ICD-10-CM	Diagnosis
I63.441	Cerebral infarction due to embolism of right cerebellar artery	ICD-10-CM	Diagnosis
I63.442	Cerebral infarction due to embolism of left cerebellar artery	ICD-10-CM	Diagnosis
I63.443	Cerebral infarction due to embolism of bilateral cerebellar arteries	ICD-10-CM	Diagnosis
I63.449	Cerebral infarction due to embolism of unspecified cerebellar artery	ICD-10-CM	Diagnosis
I63.49	Cerebral infarction due to embolism of other cerebral artery	ICD-10-CM	Diagnosis
I63.511	Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery	ICD-10-CM	Diagnosis
I63.512	Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery	ICD-10-CM	Diagnosis
I63.513	Cerebral infarction due to unspecified occlusion or stenosis of bilateral middle cerebral arteries	ICD-10-CM	Diagnosis
I63.519	Cerebral infarction due to unspecified occlusion or stenosis of unspecified middle cerebral artery	ICD-10-CM	Diagnosis
I63.521	Cerebral infarction due to unspecified occlusion or stenosis of right anterior cerebral artery	ICD-10-CM	Diagnosis
I63.522	Cerebral infarction due to unspecified occlusion or stenosis of left anterior cerebral artery	ICD-10-CM	Diagnosis
I63.523	Cerebral infarction due to unspecified occlusion or stenosis of bilateral anterior cerebral arteries	ICD-10-CM	Diagnosis
I63.529	Cerebral infarction due to unspecified occlusion or stenosis of unspecified anterior cerebral artery	ICD-10-CM	Diagnosis
I63.531	Cerebral infarction due to unspecified occlusion or stenosis of right posterior cerebral artery	ICD-10-CM	Diagnosis
I63.532	Cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery	ICD-10-CM	Diagnosis
I63.533	Cerebral infarction due to unspecified occlusion or stenosis of bilateral posterior cerebral arteries	ICD-10-CM	Diagnosis
I63.539	Cerebral infarction due to unspecified occlusion or stenosis of unspecified posterior cerebral artery	ICD-10-CM	Diagnosis
I63.541	Cerebral infarction due to unspecified occlusion or stenosis of right cerebellar artery	ICD-10-CM	Diagnosis
I63.542	Cerebral infarction due to unspecified occlusion or stenosis of left cerebellar artery	ICD-10-CM	Diagnosis
I63.543	Cerebral infarction due to unspecified occlusion or stenosis of bilateral cerebellar arteries	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I63.549	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery	ICD-10-CM	Diagnosis
I63.8	Other cerebral infarction	ICD-10-CM	Diagnosis
I63.9	Cerebral infarction, unspecified	ICD-10-CM	Diagnosis
I63	Cerebral infarction	ICD-10-CM	Diagnosis
I63.0	Cerebral infarction due to thrombosis of precerebral arteries	ICD-10-CM	Diagnosis
I63.01	Cerebral infarction due to thrombosis of vertebral artery	ICD-10-CM	Diagnosis
I63.03	Cerebral infarction due to thrombosis of carotid artery	ICD-10-CM	Diagnosis
I63.1	Cerebral infarction due to embolism of precerebral arteries	ICD-10-CM	Diagnosis
I63.11	Cerebral infarction due to embolism of vertebral artery	ICD-10-CM	Diagnosis
I63.13	Cerebral infarction due to embolism of carotid artery	ICD-10-CM	Diagnosis
I63.2	Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries	ICD-10-CM	Diagnosis
I63.21	Cerebral infarction due to unspecified occlusion or stenosis of vertebral arteries	ICD-10-CM	Diagnosis
I63.23	Cerebral infarction due to unspecified occlusion or stenosis of carotid arteries	ICD-10-CM	Diagnosis
I63.3	Cerebral infarction due to thrombosis of cerebral arteries	ICD-10-CM	Diagnosis
I63.31	Cerebral infarction due to thrombosis of middle cerebral artery	ICD-10-CM	Diagnosis
I63.32	Cerebral infarction due to thrombosis of anterior cerebral artery	ICD-10-CM	Diagnosis
I63.33	Cerebral infarction due to thrombosis of posterior cerebral artery	ICD-10-CM	Diagnosis
I63.34	Cerebral infarction due to thrombosis of cerebellar artery	ICD-10-CM	Diagnosis
I63.4	Cerebral infarction due to embolism of cerebral arteries	ICD-10-CM	Diagnosis
I63.41	Cerebral infarction due to embolism of middle cerebral artery	ICD-10-CM	Diagnosis
I63.42	Cerebral infarction due to embolism of anterior cerebral artery	ICD-10-CM	Diagnosis
I63.43	Cerebral infarction due to embolism of posterior cerebral artery	ICD-10-CM	Diagnosis
I63.44	Cerebral infarction due to embolism of cerebellar artery	ICD-10-CM	Diagnosis
I63.5	Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries	ICD-10-CM	Diagnosis
I63.51	Cerebral infarction due to unspecified occlusion or stenosis of middle cerebral artery	ICD-10-CM	Diagnosis
I63.52	Cerebral infarction due to unspecified occlusion or stenosis of anterior cerebral artery	ICD-10-CM	Diagnosis
I63.53	Cerebral infarction due to unspecified occlusion or stenosis of posterior cerebral artery	ICD-10-CM	Diagnosis
I63.54	Cerebral infarction due to unspecified occlusion or stenosis of cerebellar artery	ICD-10-CM	Diagnosis
I63.81	Other cerebral infarction due to occlusion or stenosis of small artery	ICD-10-CM	Diagnosis
I63.89	Other cerebral infarction	ICD-10-CM	Diagnosis
I60	Nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I60.0	Nontraumatic subarachnoid hemorrhage from carotid siphon and bifurcation	ICD-10-CM	Diagnosis
I60.00	Nontraumatic subarachnoid hemorrhage from unspecified carotid siphon and bifurcation	ICD-10-CM	Diagnosis
I60.01	Nontraumatic subarachnoid hemorrhage from right carotid siphon and bifurcation	ICD-10-CM	Diagnosis
I60.02	Nontraumatic subarachnoid hemorrhage from left carotid siphon and bifurcation	ICD-10-CM	Diagnosis
I60.1	Nontraumatic subarachnoid hemorrhage from middle cerebral artery	ICD-10-CM	Diagnosis
I60.10	Nontraumatic subarachnoid hemorrhage from unspecified middle cerebral artery	ICD-10-CM	Diagnosis
I60.11	Nontraumatic subarachnoid hemorrhage from right middle cerebral artery	ICD-10-CM	Diagnosis
I60.12	Nontraumatic subarachnoid hemorrhage from left middle cerebral artery	ICD-10-CM	Diagnosis
I60.2	Nontraumatic subarachnoid hemorrhage from anterior communicating artery	ICD-10-CM	Diagnosis
I60.3	Nontraumatic subarachnoid hemorrhage from posterior communicating artery	ICD-10-CM	Diagnosis
I60.30	Nontraumatic subarachnoid hemorrhage from unspecified posterior communicating artery	ICD-10-CM	Diagnosis
I60.31	Nontraumatic subarachnoid hemorrhage from right posterior communicating artery	ICD-10-CM	Diagnosis
I60.32	Nontraumatic subarachnoid hemorrhage from left posterior communicating artery	ICD-10-CM	Diagnosis
I60.4	Nontraumatic subarachnoid hemorrhage from basilar artery	ICD-10-CM	Diagnosis
I60.5	Nontraumatic subarachnoid hemorrhage from vertebral artery	ICD-10-CM	Diagnosis
I60.50	Nontraumatic subarachnoid hemorrhage from unspecified vertebral artery	ICD-10-CM	Diagnosis
I60.51	Nontraumatic subarachnoid hemorrhage from right vertebral artery	ICD-10-CM	Diagnosis
I60.52	Nontraumatic subarachnoid hemorrhage from left vertebral artery	ICD-10-CM	Diagnosis
I60.6	Nontraumatic subarachnoid hemorrhage from other intracranial arteries	ICD-10-CM	Diagnosis
I60.7	Nontraumatic subarachnoid hemorrhage from unspecified intracranial artery	ICD-10-CM	Diagnosis
I60.8	Other nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I60.9	Nontraumatic subarachnoid hemorrhage, unspecified	ICD-10-CM	Diagnosis
I61	Nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I61.0	Nontraumatic intracerebral hemorrhage in hemisphere, subcortical	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I61.1	Nontraumatic intracerebral hemorrhage in hemisphere, cortical	ICD-10-CM	Diagnosis
I61.2	Nontraumatic intracerebral hemorrhage in hemisphere, unspecified	ICD-10-CM	Diagnosis
I61.3	Nontraumatic intracerebral hemorrhage in brain stem	ICD-10-CM	Diagnosis
I61.4	Nontraumatic intracerebral hemorrhage in cerebellum	ICD-10-CM	Diagnosis
I61.5	Nontraumatic intracerebral hemorrhage, intraventricular	ICD-10-CM	Diagnosis
I61.6	Nontraumatic intracerebral hemorrhage, multiple localized	ICD-10-CM	Diagnosis
I61.8	Other nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I61.9	Nontraumatic intracerebral hemorrhage, unspecified	ICD-10-CM	Diagnosis
I62	Other and unspecified nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I62.0	Nontraumatic subdural hemorrhage	ICD-10-CM	Diagnosis
I62.00	Nontraumatic subdural hemorrhage, unspecified	ICD-10-CM	Diagnosis
I62.01	Nontraumatic acute subdural hemorrhage	ICD-10-CM	Diagnosis
I62.02	Nontraumatic subacute subdural hemorrhage	ICD-10-CM	Diagnosis
I62.03	Nontraumatic chronic subdural hemorrhage	ICD-10-CM	Diagnosis
I62.1	Nontraumatic extradural hemorrhage	ICD-10-CM	Diagnosis
I62.9	Nontraumatic intracranial hemorrhage, unspecified	ICD-10-CM	Diagnosis
I63.81	Other cerebral infarction due to occlusion or stenosis of small artery	ICD-10-CM	Diagnosis
I63.89	Other cerebral infarction	ICD-10-CM	Diagnosis
I65	Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction	ICD-10-CM	Diagnosis
I65.0	Occlusion and stenosis of vertebral artery	ICD-10-CM	Diagnosis
I65.01	Occlusion and stenosis of right vertebral artery	ICD-10-CM	Diagnosis
I65.02	Occlusion and stenosis of left vertebral artery	ICD-10-CM	Diagnosis
I65.03	Occlusion and stenosis of bilateral vertebral arteries	ICD-10-CM	Diagnosis
I65.09	Occlusion and stenosis of unspecified vertebral artery	ICD-10-CM	Diagnosis
I65.1	Occlusion and stenosis of basilar artery	ICD-10-CM	Diagnosis
I65.2	Occlusion and stenosis of carotid artery	ICD-10-CM	Diagnosis
I65.21	Occlusion and stenosis of right carotid artery	ICD-10-CM	Diagnosis
I65.22	Occlusion and stenosis of left carotid artery	ICD-10-CM	Diagnosis
I65.23	Occlusion and stenosis of bilateral carotid arteries	ICD-10-CM	Diagnosis
I65.29	Occlusion and stenosis of unspecified carotid artery	ICD-10-CM	Diagnosis
I65.8	Occlusion and stenosis of other precerebral arteries	ICD-10-CM	Diagnosis
I65.9	Occlusion and stenosis of unspecified precerebral artery	ICD-10-CM	Diagnosis
I66	Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction	ICD-10-CM	Diagnosis
I66.0	Occlusion and stenosis of middle cerebral artery	ICD-10-CM	Diagnosis
I66.01	Occlusion and stenosis of right middle cerebral artery	ICD-10-CM	Diagnosis
I66.02	Occlusion and stenosis of left middle cerebral artery	ICD-10-CM	Diagnosis
I66.03	Occlusion and stenosis of bilateral middle cerebral arteries	ICD-10-CM	Diagnosis
I66.09	Occlusion and stenosis of unspecified middle cerebral artery	ICD-10-CM	Diagnosis
I66.1	Occlusion and stenosis of anterior cerebral artery	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I66.11	Occlusion and stenosis of right anterior cerebral artery	ICD-10-CM	Diagnosis
I66.12	Occlusion and stenosis of left anterior cerebral artery	ICD-10-CM	Diagnosis
I66.13	Occlusion and stenosis of bilateral anterior cerebral arteries	ICD-10-CM	Diagnosis
I66.19	Occlusion and stenosis of unspecified anterior cerebral artery	ICD-10-CM	Diagnosis
I66.2	Occlusion and stenosis of posterior cerebral artery	ICD-10-CM	Diagnosis
I66.21	Occlusion and stenosis of right posterior cerebral artery	ICD-10-CM	Diagnosis
I66.22	Occlusion and stenosis of left posterior cerebral artery	ICD-10-CM	Diagnosis
I66.23	Occlusion and stenosis of bilateral posterior cerebral arteries	ICD-10-CM	Diagnosis
I66.29	Occlusion and stenosis of unspecified posterior cerebral artery	ICD-10-CM	Diagnosis
I66.3	Occlusion and stenosis of cerebellar arteries	ICD-10-CM	Diagnosis
I66.8	Occlusion and stenosis of other cerebral arteries	ICD-10-CM	Diagnosis
I66.9	Occlusion and stenosis of unspecified cerebral artery	ICD-10-CM	Diagnosis
I67	Other cerebrovascular diseases	ICD-10-CM	Diagnosis
I67.0	Dissection of cerebral arteries, nonruptured	ICD-10-CM	Diagnosis
I67.1	Cerebral aneurysm, nonruptured	ICD-10-CM	Diagnosis
I67.2	Cerebral atherosclerosis	ICD-10-CM	Diagnosis
I67.3	Progressive vascular leukoencephalopathy	ICD-10-CM	Diagnosis
I67.4	Hypertensive encephalopathy	ICD-10-CM	Diagnosis
I67.5	Moyamoya disease	ICD-10-CM	Diagnosis
I67.7	Cerebral arteritis, not elsewhere classified	ICD-10-CM	Diagnosis
I67.8	Other specified cerebrovascular diseases	ICD-10-CM	Diagnosis
I67.81	Acute cerebrovascular insufficiency	ICD-10-CM	Diagnosis
I67.82	Cerebral ischemia	ICD-10-CM	Diagnosis
I67.83	Posterior reversible encephalopathy syndrome	ICD-10-CM	Diagnosis
I67.84	Cerebral vasospasm and vasoconstriction	ICD-10-CM	Diagnosis
I67.85	Hereditary cerebrovascular diseases	ICD-10-CM	Diagnosis
I67.850	Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy	ICD-10-CM	Diagnosis
I67.858	Other hereditary cerebrovascular disease	ICD-10-CM	Diagnosis
I67.9	Cerebrovascular disease, unspecified	ICD-10-CM	Diagnosis
I68	Cerebrovascular disorders in diseases classified elsewhere	ICD-10-CM	Diagnosis
I68.0	Cerebral amyloid angiopathy	ICD-10-CM	Diagnosis
I68.2	Cerebral arteritis in other diseases classified elsewhere	ICD-10-CM	Diagnosis
I68.8	Other cerebrovascular disorders in diseases classified elsewhere	ICD-10-CM	Diagnosis
G45.8	Other transient cerebral ischemic attacks and related syndromes	ICD-10-CM	Diagnosis
G45	Transient cerebral ischemic attacks and related syndromes	ICD-10-CM	Diagnosis
G45.9	Transient cerebral ischemic attack, unspecified	ICD-10-CM	Diagnosis
G45.0	Vertebro-basilar artery syndrome	ICD-10-CM	Diagnosis
G45.1	Carotid artery syndrome (hemispheric)	ICD-10-CM	Diagnosis
G45.2	Multiple and bilateral precerebral artery syndromes	ICD-10-CM	Diagnosis
G46.0	Middle cerebral artery syndrome	ICD-10-CM	Diagnosis
G46.1	Anterior cerebral artery syndrome	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
G46.2	Posterior cerebral artery syndrome	ICD-10-CM	Diagnosis
I67.841	Reversible cerebrovascular vasoconstriction syndrome	ICD-10-CM	Diagnosis
I67.848	Other cerebrovascular vasospasm and vasoconstriction	ICD-10-CM	Diagnosis
Q28.2	Arteriovenous malformation of cerebral vessels	ICD-10-CM	Diagnosis
Q28.0	Arteriovenous malformation of precerebral vessels	ICD-10-CM	Diagnosis
I67.89	Other cerebrovascular disease	ICD-10-CM	Diagnosis
61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	ICD-10-CM	Diagnosis
61635	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	ICD-10-CM	Diagnosis
I69	Sequelae of cerebrovascular disease	ICD-10-CM	Diagnosis
I69.0	Sequelae of nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.00	Unspecified sequelae of nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.01	Cognitive deficits following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.010	Attention and concentration deficit following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.011	Memory deficit following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.012	Visuospatial deficit and spatial neglect following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.013	Psychomotor deficit following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.014	Frontal lobe and executive function deficit following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.015	Cognitive social or emotional deficit following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.018	Other symptoms and signs involving cognitive functions following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.019	Unspecified symptoms and signs involving cognitive functions following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.02	Speech and language deficits following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.020	Aphasia following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.021	Dysphasia following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.022	Dysarthria following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.023	Fluency disorder following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.028	Other speech and language deficits following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.03	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I69.031	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.032	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.033	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.034	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.039	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.04	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.041	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.042	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.043	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.044	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.049	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.05	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.051	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.052	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.053	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.054	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.059	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.06	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.061	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.062	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.063	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.064	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I69.065	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage, bilateral	ICD-10-CM	Diagnosis
I69.069	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.09	Other sequelae of nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.090	Apraxia following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.091	Dysphagia following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.092	Facial weakness following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.093	Ataxia following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.098	Other sequelae following nontraumatic subarachnoid hemorrhage	ICD-10-CM	Diagnosis
I69.1	Sequelae of nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.10	Unspecified sequelae of nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.11	Cognitive deficits following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.110	Attention and concentration deficit following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.111	Memory deficit following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.112	Visuospatial deficit and spatial neglect following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.113	Psychomotor deficit following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.114	Frontal lobe and executive function deficit following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.115	Cognitive social or emotional deficit following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.118	Other symptoms and signs involving cognitive functions following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.119	Unspecified symptoms and signs involving cognitive functions following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.12	Speech and language deficits following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.120	Aphasia following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.121	Dysphasia following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.122	Dysarthria following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.123	Fluency disorder following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.128	Other speech and language deficits following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.13	Monoplegia of upper limb following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I69.131	Monoplegia of upper limb following nontraumatic intracerebral hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.132	Monoplegia of upper limb following nontraumatic intracerebral hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.133	Monoplegia of upper limb following nontraumatic intracerebral hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.134	Monoplegia of upper limb following nontraumatic intracerebral hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.139	Monoplegia of upper limb following nontraumatic intracerebral hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.14	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.141	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.142	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.143	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.144	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.149	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.15	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.151	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.152	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.153	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.154	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.159	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.16	Other paralytic syndrome following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.161	Other paralytic syndrome following nontraumatic intracerebral hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.162	Other paralytic syndrome following nontraumatic intracerebral hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.163	Other paralytic syndrome following nontraumatic intracerebral hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.164	Other paralytic syndrome following nontraumatic intracerebral hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I69.165	Other paralytic syndrome following nontraumatic intracerebral hemorrhage, bilateral	ICD-10-CM	Diagnosis
I69.169	Other paralytic syndrome following nontraumatic intracerebral hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.19	Other sequelae of nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.190	Apraxia following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.191	Dysphagia following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.192	Facial weakness following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.193	Ataxia following nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.198	Other sequelae of nontraumatic intracerebral hemorrhage	ICD-10-CM	Diagnosis
I69.2	Sequelae of other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.20	Unspecified sequelae of other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.21	Cognitive deficits following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.210	Attention and concentration deficit following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.211	Memory deficit following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.212	Visuospatial deficit and spatial neglect following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.213	Psychomotor deficit following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.214	Frontal lobe and executive function deficit following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.215	Cognitive social or emotional deficit following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.218	Other symptoms and signs involving cognitive functions following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.219	Unspecified symptoms and signs involving cognitive functions following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.22	Speech and language deficits following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.220	Aphasia following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.221	Dysphasia following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.222	Dysarthria following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.223	Fluency disorder following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.228	Other speech and language deficits following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I69.23	Monoplegia of upper limb following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.231	Monoplegia of upper limb following other nontraumatic intracranial hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.232	Monoplegia of upper limb following other nontraumatic intracranial hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.233	Monoplegia of upper limb following other nontraumatic intracranial hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.234	Monoplegia of upper limb following other nontraumatic intracranial hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.239	Monoplegia of upper limb following other nontraumatic intracranial hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.24	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.241	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.242	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.243	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.244	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.249	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.25	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.251	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.252	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.253	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.254	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.259	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.26	Other paralytic syndrome following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.261	Other paralytic syndrome following other nontraumatic intracranial hemorrhage affecting right dominant side	ICD-10-CM	Diagnosis
I69.262	Other paralytic syndrome following other nontraumatic intracranial hemorrhage affecting left dominant side	ICD-10-CM	Diagnosis
I69.263	Other paralytic syndrome following other nontraumatic intracranial hemorrhage affecting right non-dominant side	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I69.264	Other paralytic syndrome following other nontraumatic intracranial hemorrhage affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.265	Other paralytic syndrome following other nontraumatic intracranial hemorrhage, bilateral	ICD-10-CM	Diagnosis
I69.269	Other paralytic syndrome following other nontraumatic intracranial hemorrhage affecting unspecified side	ICD-10-CM	Diagnosis
I69.29	Other sequelae of other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.290	Apraxia following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.291	Dysphagia following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.292	Facial weakness following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.293	Ataxia following other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.298	Other sequelae of other nontraumatic intracranial hemorrhage	ICD-10-CM	Diagnosis
I69.8	Sequelae of other cerebrovascular diseases	ICD-10-CM	Diagnosis
I69.80	Unspecified sequelae of other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.81	Cognitive deficits following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.810	Attention and concentration deficit following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.811	Memory deficit following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.812	Visuospatial deficit and spatial neglect following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.813	Psychomotor deficit following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.814	Frontal lobe and executive function deficit following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.815	Cognitive social or emotional deficit following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.818	Other symptoms and signs involving cognitive functions following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.819	Unspecified symptoms and signs involving cognitive functions following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.82	Speech and language deficits following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.820	Aphasia following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.821	Dysphasia following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.822	Dysarthria following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.823	Fluency disorder following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.828	Other speech and language deficits following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.83	Monoplegia of upper limb following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.831	Monoplegia of upper limb following other cerebrovascular disease affecting right dominant side	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I69.832	Monoplegia of upper limb following other cerebrovascular disease affecting left dominant side	ICD-10-CM	Diagnosis
I69.833	Monoplegia of upper limb following other cerebrovascular disease affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.834	Monoplegia of upper limb following other cerebrovascular disease affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.839	Monoplegia of upper limb following other cerebrovascular disease affecting unspecified side	ICD-10-CM	Diagnosis
I69.84	Monoplegia of lower limb following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.841	Monoplegia of lower limb following other cerebrovascular disease affecting right dominant side	ICD-10-CM	Diagnosis
I69.842	Monoplegia of lower limb following other cerebrovascular disease affecting left dominant side	ICD-10-CM	Diagnosis
I69.843	Monoplegia of lower limb following other cerebrovascular disease affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.844	Monoplegia of lower limb following other cerebrovascular disease affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.849	Monoplegia of lower limb following other cerebrovascular disease affecting unspecified side	ICD-10-CM	Diagnosis
I69.85	Hemiplegia and hemiparesis following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.851	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side	ICD-10-CM	Diagnosis
I69.852	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left dominant side	ICD-10-CM	Diagnosis
I69.853	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.854	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.859	Hemiplegia and hemiparesis following other cerebrovascular disease affecting unspecified side	ICD-10-CM	Diagnosis
I69.86	Other paralytic syndrome following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.861	Other paralytic syndrome following other cerebrovascular disease affecting right dominant side	ICD-10-CM	Diagnosis
I69.862	Other paralytic syndrome following other cerebrovascular disease affecting left dominant side	ICD-10-CM	Diagnosis
I69.863	Other paralytic syndrome following other cerebrovascular disease affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.864	Other paralytic syndrome following other cerebrovascular disease affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.865	Other paralytic syndrome following other cerebrovascular disease, bilateral	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I69.869	Other paralytic syndrome following other cerebrovascular disease affecting unspecified side	ICD-10-CM	Diagnosis
I69.89	Other sequelae of other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.890	Apraxia following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.891	Dysphagia following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.892	Facial weakness following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.893	Ataxia following other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.898	Other sequelae of other cerebrovascular disease	ICD-10-CM	Diagnosis
I69.9	Sequelae of unspecified cerebrovascular diseases	ICD-10-CM	Diagnosis
I69.90	Unspecified sequelae of unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.91	Cognitive deficits following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.910	Attention and concentration deficit following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.911	Memory deficit following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.912	Visuospatial deficit and spatial neglect following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.913	Psychomotor deficit following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.914	Frontal lobe and executive function deficit following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.915	Cognitive social or emotional deficit following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.918	Other symptoms and signs involving cognitive functions following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.919	Unspecified symptoms and signs involving cognitive functions following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.92	Speech and language deficits following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.920	Aphasia following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.921	Dysphasia following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.922	Dysarthria following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.923	Fluency disorder following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.928	Other speech and language deficits following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.93	Monoplegia of upper limb following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.931	Monoplegia of upper limb following unspecified cerebrovascular disease affecting right dominant side	ICD-10-CM	Diagnosis
I69.932	Monoplegia of upper limb following unspecified cerebrovascular disease affecting left dominant side	ICD-10-CM	Diagnosis
I69.933	Monoplegia of upper limb following unspecified cerebrovascular disease affecting right non-dominant side	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
I69.934	Monoplegia of upper limb following unspecified cerebrovascular disease affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.939	Monoplegia of upper limb following unspecified cerebrovascular disease affecting unspecified side	ICD-10-CM	Diagnosis
I69.94	Monoplegia of lower limb following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.941	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right dominant side	ICD-10-CM	Diagnosis
I69.942	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left dominant side	ICD-10-CM	Diagnosis
I69.943	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.944	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.949	Monoplegia of lower limb following unspecified cerebrovascular disease affecting unspecified side	ICD-10-CM	Diagnosis
I69.95	Hemiplegia and hemiparesis following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.951	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side	ICD-10-CM	Diagnosis
I69.952	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side	ICD-10-CM	Diagnosis
I69.953	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.954	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side	ICD-10-CM	Diagnosis
I69.96	Other paralytic syndrome following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.961	Other paralytic syndrome following unspecified cerebrovascular disease affecting right dominant side	ICD-10-CM	Diagnosis
I69.962	Other paralytic syndrome following unspecified cerebrovascular disease affecting left dominant side	ICD-10-CM	Diagnosis
I69.963	Other paralytic syndrome following unspecified cerebrovascular disease affecting right non-dominant side	ICD-10-CM	Diagnosis
I69.964	Other paralytic syndrome following unspecified cerebrovascular disease affecting left non-dominant side	ICD-10-CM	Diagnosis
I69.965	Other paralytic syndrome following unspecified cerebrovascular disease, bilateral	ICD-10-CM	Diagnosis
I69.969	Other paralytic syndrome following unspecified cerebrovascular disease affecting unspecified side	ICD-10-CM	Diagnosis
I69.99	Other sequelae of unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.990	Apraxia following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I69.991	Dysphagia following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.992	Facial weakness following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.993	Ataxia following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I69.998	Other sequelae following unspecified cerebrovascular disease	ICD-10-CM	Diagnosis
I20	Angina pectoris	ICD-10-CM	Diagnosis
I20.0	Unstable angina	ICD-10-CM	Diagnosis
I20.1	Angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I20.8	Other forms of angina pectoris	ICD-10-CM	Diagnosis
I20.9	Angina pectoris, unspecified	ICD-10-CM	Diagnosis
I23.7	Postinfarction angina	ICD-10-CM	Diagnosis
I24	Other acute ischemic heart diseases	ICD-10-CM	Diagnosis
I24.0	Acute coronary thrombosis not resulting in myocardial infarction	ICD-10-CM	Diagnosis
I24.8	Other forms of acute ischemic heart disease	ICD-10-CM	Diagnosis
I24.9	Acute ischemic heart disease, unspecified	ICD-10-CM	Diagnosis
I25.11	Atherosclerotic heart disease of native coronary artery with angina pectoris	ICD-10-CM	Diagnosis
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.111	Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.6	Silent myocardial ischemia	ICD-10-CM	Diagnosis
I25.7	Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris	ICD-10-CM	Diagnosis
I25.70	Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris	ICD-10-CM	Diagnosis
I25.700	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.701	Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.708	Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.709	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.71	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris	ICD-10-CM	Diagnosis
I25.710	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.711	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
I25.718	Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.719	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.72	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris	ICD-10-CM	Diagnosis
I25.720	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.721	Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.728	Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.729	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.73	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris	ICD-10-CM	Diagnosis
I25.730	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.731	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.738	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.739	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.75	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris	ICD-10-CM	Diagnosis
I25.750	Atherosclerosis of native coronary artery of transplanted heart with unstable angina	ICD-10-CM	Diagnosis
I25.751	Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.758	Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.759	Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.76	Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris	ICD-10-CM	Diagnosis
I25.760	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina	ICD-10-CM	Diagnosis
I25.761	Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.768	Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I25.769	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.79	Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris	ICD-10-CM	Diagnosis
I25.790	Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris	ICD-10-CM	Diagnosis
I25.791	Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm	ICD-10-CM	Diagnosis
I25.798	Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris	ICD-10-CM	Diagnosis
I25.799	Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris	ICD-10-CM	Diagnosis
I25.83	Coronary atherosclerosis due to lipid rich plaque	ICD-10-CM	Diagnosis
I25.84	Coronary atherosclerosis due to calcified coronary lesion	ICD-10-CM	Diagnosis
I46.2	Cardiac arrest due to underlying cardiac condition	ICD-10-CM	Diagnosis
I46.8	Cardiac arrest due to other underlying condition	ICD-10-CM	Diagnosis
I46.9	Cardiac arrest, cause unspecified	ICD-10-CM	Diagnosis
I47.0	Re-entry ventricular arrhythmia	ICD-10-CM	Diagnosis
I47.2	Ventricular tachycardia	ICD-10-CM	Diagnosis
Z95.1	Presence of aortocoronary bypass graft	ICD-10-CM	Diagnosis
Z95.5	Presence of coronary angioplasty implant and graft	ICD-10-CM	Diagnosis
M62.2	Nontraumatic ischemic infarction of muscle	ICD-10-CM	Diagnosis
M62.20	Nontraumatic ischemic infarction of muscle, unspecified site	ICD-10-CM	Diagnosis
M62.21	Nontraumatic ischemic infarction of muscle, shoulder	ICD-10-CM	Diagnosis
M62.211	Nontraumatic ischemic infarction of muscle, right shoulder	ICD-10-CM	Diagnosis
M62.212	Nontraumatic ischemic infarction of muscle, left shoulder	ICD-10-CM	Diagnosis
M62.219	Nontraumatic ischemic infarction of muscle, unspecified shoulder	ICD-10-CM	Diagnosis
M62.22	Nontraumatic ischemic infarction of muscle, upper arm	ICD-10-CM	Diagnosis
M62.221	Nontraumatic ischemic infarction of muscle, right upper arm	ICD-10-CM	Diagnosis
M62.222	Nontraumatic ischemic infarction of muscle, left upper arm	ICD-10-CM	Diagnosis
M62.229	Nontraumatic ischemic infarction of muscle, unspecified upper arm	ICD-10-CM	Diagnosis
M62.23	Nontraumatic ischemic infarction of muscle, forearm	ICD-10-CM	Diagnosis
M62.231	Nontraumatic ischemic infarction of muscle, right forearm	ICD-10-CM	Diagnosis
M62.232	Nontraumatic ischemic infarction of muscle, left forearm	ICD-10-CM	Diagnosis
M62.239	Nontraumatic ischemic infarction of muscle, unspecified forearm	ICD-10-CM	Diagnosis
M62.24	Nontraumatic ischemic infarction of muscle, hand	ICD-10-CM	Diagnosis
M62.241	Nontraumatic ischemic infarction of muscle, right hand	ICD-10-CM	Diagnosis
M62.242	Nontraumatic ischemic infarction of muscle, left hand	ICD-10-CM	Diagnosis
M62.249	Nontraumatic ischemic infarction of muscle, unspecified hand	ICD-10-CM	Diagnosis
M62.25	Nontraumatic ischemic infarction of muscle, thigh	ICD-10-CM	Diagnosis
M62.251	Nontraumatic ischemic infarction of muscle, right thigh	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M62.252	Nontraumatic ischemic infarction of muscle, left thigh	ICD-10-CM	Diagnosis
M62.259	Nontraumatic ischemic infarction of muscle, unspecified thigh	ICD-10-CM	Diagnosis
M62.26	Nontraumatic ischemic infarction of muscle, lower leg	ICD-10-CM	Diagnosis
M62.261	Nontraumatic ischemic infarction of muscle, right lower leg	ICD-10-CM	Diagnosis
M62.262	Nontraumatic ischemic infarction of muscle, left lower leg	ICD-10-CM	Diagnosis
M62.269	Nontraumatic ischemic infarction of muscle, unspecified lower leg	ICD-10-CM	Diagnosis
M62.27	Nontraumatic ischemic infarction of muscle, ankle and foot	ICD-10-CM	Diagnosis
M62.271	Nontraumatic ischemic infarction of muscle, right ankle and foot	ICD-10-CM	Diagnosis
M62.272	Nontraumatic ischemic infarction of muscle, left ankle and foot	ICD-10-CM	Diagnosis
M62.279	Nontraumatic ischemic infarction of muscle, unspecified ankle and foot	ICD-10-CM	Diagnosis
M62.28	Nontraumatic ischemic infarction of muscle, other site	ICD-10-CM	Diagnosis
I70.3	Atherosclerosis of unspecified type of bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.30	Unspecified atherosclerosis of unspecified type of bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.301	Unspecified atherosclerosis of unspecified type of bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis
I70.302	Unspecified atherosclerosis of unspecified type of bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis
I70.303	Unspecified atherosclerosis of unspecified type of bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.308	Unspecified atherosclerosis of unspecified type of bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.309	Unspecified atherosclerosis of unspecified type of bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.31	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication	ICD-10-CM	Diagnosis
I70.311	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication, right leg	ICD-10-CM	Diagnosis
I70.312	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication, left leg	ICD-10-CM	Diagnosis
I70.313	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication, bilateral legs	ICD-10-CM	Diagnosis
I70.318	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication, other extremity	ICD-10-CM	Diagnosis
I70.319	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication, unspecified extremity	ICD-10-CM	Diagnosis
I70.32	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.321	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain, right leg	ICD-10-CM	Diagnosis
I70.322	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain, left leg	ICD-10-CM	Diagnosis
I70.323	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain, bilateral legs	ICD-10-CM	Diagnosis
I70.328	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain, other extremity	ICD-10-CM	Diagnosis
I70.329	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain, unspecified extremity	ICD-10-CM	Diagnosis
I70.33	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration	ICD-10-CM	Diagnosis
I70.331	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.332	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.333	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.334	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.335	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.338	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.339	Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.34	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration	ICD-10-CM	Diagnosis
I70.341	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.342	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.343	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.344	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.345	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.348	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.349	Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.35	Atherosclerosis of unspecified type of bypass graft(s) of other extremity with ulceration	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.39	Other atherosclerosis of unspecified type of bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.391	Other atherosclerosis of unspecified type of bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis
I70.392	Other atherosclerosis of unspecified type of bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis
I70.393	Other atherosclerosis of unspecified type of bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.398	Other atherosclerosis of unspecified type of bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.399	Other atherosclerosis of unspecified type of bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.4	Atherosclerosis of autologous vein bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.40	Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.401	Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis
I70.402	Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis
I70.403	Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.408	Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.409	Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.41	Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication	ICD-10-CM	Diagnosis
I70.411	Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, right leg	ICD-10-CM	Diagnosis
I70.412	Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, left leg	ICD-10-CM	Diagnosis
I70.413	Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, bilateral legs	ICD-10-CM	Diagnosis
I70.418	Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, other extremity	ICD-10-CM	Diagnosis
I70.419	Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, unspecified extremity	ICD-10-CM	Diagnosis
I70.42	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain	ICD-10-CM	Diagnosis
I70.421	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain, right leg	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.422	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain, left leg	ICD-10-CM	Diagnosis
I70.423	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain, bilateral legs	ICD-10-CM	Diagnosis
I70.428	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain, other extremity	ICD-10-CM	Diagnosis
I70.429	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain, unspecified extremity	ICD-10-CM	Diagnosis
I70.43	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration	ICD-10-CM	Diagnosis
I70.431	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.432	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.433	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.434	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.435	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.438	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.439	Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.44	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration	ICD-10-CM	Diagnosis
I70.441	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.442	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.443	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.444	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.445	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.448	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.449	Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.45	Atherosclerosis of autologous vein bypass graft(s) of other extremity with ulceration	ICD-10-CM	Diagnosis
I70.49	Other atherosclerosis of autologous vein bypass graft(s) of the extremities	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
I70.491	Other atherosclerosis of autologous vein bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis
I70.492	Other atherosclerosis of autologous vein bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis
I70.493	Other atherosclerosis of autologous vein bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.498	Other atherosclerosis of autologous vein bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.499	Other atherosclerosis of autologous vein bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.5	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.50	Unspecified atherosclerosis of nonautologous biological bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.501	Unspecified atherosclerosis of nonautologous biological bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis
I70.502	Unspecified atherosclerosis of nonautologous biological bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis
I70.503	Unspecified atherosclerosis of nonautologous biological bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.508	Unspecified atherosclerosis of nonautologous biological bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.509	Unspecified atherosclerosis of nonautologous biological bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.51	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities intermittent claudication	ICD-10-CM	Diagnosis
I70.511	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, right leg	ICD-10-CM	Diagnosis
I70.512	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, left leg	ICD-10-CM	Diagnosis
I70.513	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, bilateral legs	ICD-10-CM	Diagnosis
I70.518	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, other extremity	ICD-10-CM	Diagnosis
I70.519	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication, unspecified extremity	ICD-10-CM	Diagnosis
I70.52	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with rest pain	ICD-10-CM	Diagnosis
I70.521	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with rest pain, right leg	ICD-10-CM	Diagnosis
I70.522	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with rest pain, left leg	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.523	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with rest pain, bilateral legs	ICD-10-CM	Diagnosis
I70.528	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with rest pain, other extremity	ICD-10-CM	Diagnosis
I70.529	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with rest pain, unspecified extremity	ICD-10-CM	Diagnosis
I70.53	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration	ICD-10-CM	Diagnosis
I70.531	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.532	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.533	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.534	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.535	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.538	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.539	Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.54	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration	ICD-10-CM	Diagnosis
I70.541	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.542	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.543	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.544	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.545	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.548	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.549	Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.55	Atherosclerosis of nonautologous biological bypass graft(s) of other extremity with ulceration	ICD-10-CM	Diagnosis
I70.59	Other atherosclerosis of nonautologous biological bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.591	Other atherosclerosis of nonautologous biological bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.592	Other atherosclerosis of nonautologous biological bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis
I70.593	Other atherosclerosis of nonautologous biological bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.598	Other atherosclerosis of nonautologous biological bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.599	Other atherosclerosis of nonautologous biological bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.6	Atherosclerosis of nonbiological bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.60	Unspecified atherosclerosis of nonbiological bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.601	Unspecified atherosclerosis of nonbiological bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis
I70.602	Unspecified atherosclerosis of nonbiological bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis
I70.603	Unspecified atherosclerosis of nonbiological bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.608	Unspecified atherosclerosis of nonbiological bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.609	Unspecified atherosclerosis of nonbiological bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.61	Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication	ICD-10-CM	Diagnosis
I70.611	Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication, right leg	ICD-10-CM	Diagnosis
I70.612	Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication, left leg	ICD-10-CM	Diagnosis
I70.613	Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication, bilateral legs	ICD-10-CM	Diagnosis
I70.618	Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication, other extremity	ICD-10-CM	Diagnosis
I70.619	Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication, unspecified extremity	ICD-10-CM	Diagnosis
I70.62	Atherosclerosis of nonbiological bypass graft(s) of the extremities with rest pain	ICD-10-CM	Diagnosis
I70.621	Atherosclerosis of nonbiological bypass graft(s) of the extremities with rest pain, right leg	ICD-10-CM	Diagnosis
I70.622	Atherosclerosis of nonbiological bypass graft(s) of the extremities with rest pain, left leg	ICD-10-CM	Diagnosis
I70.623	Atherosclerosis of nonbiological bypass graft(s) of the extremities with rest pain, bilateral legs	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.628	Atherosclerosis of nonbiological bypass graft(s) of the extremities with rest pain, other extremity	ICD-10-CM	Diagnosis
I70.629	Atherosclerosis of nonbiological bypass graft(s) of the extremities with rest pain, unspecified extremity	ICD-10-CM	Diagnosis
I70.63	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration	ICD-10-CM	Diagnosis
I70.631	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.632	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.633	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.634	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.635	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.638	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.639	Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.64	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration	ICD-10-CM	Diagnosis
I70.641	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.642	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.643	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.644	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.645	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.648	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.649	Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.65	Atherosclerosis of nonbiological bypass graft(s) of other extremity with ulceration	ICD-10-CM	Diagnosis
I70.69	Other atherosclerosis of nonbiological bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.691	Other atherosclerosis of nonbiological bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis
I70.692	Other atherosclerosis of nonbiological bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.693	Other atherosclerosis of nonbiological bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.698	Other atherosclerosis of nonbiological bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.699	Other atherosclerosis of nonbiological bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.7	Atherosclerosis of other type of bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.70	Unspecified atherosclerosis of other type of bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.701	Unspecified atherosclerosis of other type of bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis
I70.702	Unspecified atherosclerosis of other type of bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis
I70.703	Unspecified atherosclerosis of other type of bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.708	Unspecified atherosclerosis of other type of bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.709	Unspecified atherosclerosis of other type of bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.71	Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication	ICD-10-CM	Diagnosis
I70.711	Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication, right leg	ICD-10-CM	Diagnosis
I70.712	Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication, left leg	ICD-10-CM	Diagnosis
I70.713	Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication, bilateral legs	ICD-10-CM	Diagnosis
I70.718	Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication, other extremity	ICD-10-CM	Diagnosis
I70.719	Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication, unspecified extremity	ICD-10-CM	Diagnosis
I70.72	Atherosclerosis of other type of bypass graft(s) of the extremities with rest pain	ICD-10-CM	Diagnosis
I70.721	Atherosclerosis of other type of bypass graft(s) of the extremities with rest pain, right leg	ICD-10-CM	Diagnosis
I70.722	Atherosclerosis of other type of bypass graft(s) of the extremities with rest pain, left leg	ICD-10-CM	Diagnosis
I70.723	Atherosclerosis of other type of bypass graft(s) of the extremities with rest pain, bilateral legs	ICD-10-CM	Diagnosis
I70.728	Atherosclerosis of other type of bypass graft(s) of the extremities with rest pain, other extremity	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.729	Atherosclerosis of other type of bypass graft(s) of the extremities with rest pain, unspecified extremity	ICD-10-CM	Diagnosis
I70.73	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration	ICD-10-CM	Diagnosis
I70.731	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.732	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.733	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.734	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.735	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.738	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.739	Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.74	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration	ICD-10-CM	Diagnosis
I70.741	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.742	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.743	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.744	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.745	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.748	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.749	Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.75	Atherosclerosis of other type of bypass graft(s) of other extremity with ulceration	ICD-10-CM	Diagnosis
I70.79	Other atherosclerosis of other type of bypass graft(s) of the extremities	ICD-10-CM	Diagnosis
I70.791	Other atherosclerosis of other type of bypass graft(s) of the extremities, right leg	ICD-10-CM	Diagnosis
I70.792	Other atherosclerosis of other type of bypass graft(s) of the extremities, left leg	ICD-10-CM	Diagnosis
I70.793	Other atherosclerosis of other type of bypass graft(s) of the extremities, bilateral legs	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.798	Other atherosclerosis of other type of bypass graft(s) of the extremities, other extremity	ICD-10-CM	Diagnosis
I70.799	Other atherosclerosis of other type of bypass graft(s) of the extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.92	Chronic total occlusion of artery of the extremities	ICD-10-CM	Diagnosis
I70.2	Atherosclerosis of native arteries of the extremities	ICD-10-CM	Diagnosis
I70.20	Unspecified atherosclerosis of native arteries of extremities	ICD-10-CM	Diagnosis
I70.201	Unspecified atherosclerosis of native arteries of extremities, right leg	ICD-10-CM	Diagnosis
I70.202	Unspecified atherosclerosis of native arteries of extremities, left leg	ICD-10-CM	Diagnosis
I70.203	Unspecified atherosclerosis of native arteries of extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.208	Unspecified atherosclerosis of native arteries of extremities, other extremity	ICD-10-CM	Diagnosis
I70.209	Unspecified atherosclerosis of native arteries of extremities, unspecified extremity	ICD-10-CM	Diagnosis
I70.21	Atherosclerosis of native arteries of extremities with intermittent claudication	ICD-10-CM	Diagnosis
I70.211	Atherosclerosis of native arteries of extremities with intermittent claudication, right leg	ICD-10-CM	Diagnosis
I70.212	Atherosclerosis of native arteries of extremities with intermittent claudication, left leg	ICD-10-CM	Diagnosis
I70.213	Atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs	ICD-10-CM	Diagnosis
I70.218	Atherosclerosis of native arteries of extremities with intermittent claudication, other extremity	ICD-10-CM	Diagnosis
I70.219	Atherosclerosis of native arteries of extremities with intermittent claudication, unspecified extremity	ICD-10-CM	Diagnosis
I70.22	Atherosclerosis of native arteries of extremities with rest pain	ICD-10-CM	Diagnosis
I70.221	Atherosclerosis of native arteries of extremities with rest pain, right leg	ICD-10-CM	Diagnosis
I70.222	Atherosclerosis of native arteries of extremities with rest pain, left leg	ICD-10-CM	Diagnosis
I70.223	Atherosclerosis of native arteries of extremities with rest pain, bilateral legs	ICD-10-CM	Diagnosis
I70.228	Atherosclerosis of native arteries of extremities with rest pain, other extremity	ICD-10-CM	Diagnosis
I70.229	Atherosclerosis of native arteries of extremities with rest pain, unspecified extremity	ICD-10-CM	Diagnosis
I70.23	Atherosclerosis of native arteries of right leg with ulceration	ICD-10-CM	Diagnosis
I70.231	Atherosclerosis of native arteries of right leg with ulceration of thigh	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.232	Atherosclerosis of native arteries of right leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.233	Atherosclerosis of native arteries of right leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.234	Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.235	Atherosclerosis of native arteries of right leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.238	Atherosclerosis of native arteries of right leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.239	Atherosclerosis of native arteries of right leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.24	Atherosclerosis of native arteries of left leg with ulceration	ICD-10-CM	Diagnosis
I70.241	Atherosclerosis of native arteries of left leg with ulceration of thigh	ICD-10-CM	Diagnosis
I70.242	Atherosclerosis of native arteries of left leg with ulceration of calf	ICD-10-CM	Diagnosis
I70.243	Atherosclerosis of native arteries of left leg with ulceration of ankle	ICD-10-CM	Diagnosis
I70.244	Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot	ICD-10-CM	Diagnosis
I70.245	Atherosclerosis of native arteries of left leg with ulceration of other part of foot	ICD-10-CM	Diagnosis
I70.248	Atherosclerosis of native arteries of left leg with ulceration of other part of lower leg	ICD-10-CM	Diagnosis
I70.249	Atherosclerosis of native arteries of left leg with ulceration of unspecified site	ICD-10-CM	Diagnosis
I70.25	Atherosclerosis of native arteries of other extremities with ulceration	ICD-10-CM	Diagnosis
I70.29	Other atherosclerosis of native arteries of extremities	ICD-10-CM	Diagnosis
I70.291	Other atherosclerosis of native arteries of extremities, right leg	ICD-10-CM	Diagnosis
I70.292	Other atherosclerosis of native arteries of extremities, left leg	ICD-10-CM	Diagnosis
I70.293	Other atherosclerosis of native arteries of extremities, bilateral legs	ICD-10-CM	Diagnosis
I70.298	Other atherosclerosis of native arteries of extremities, other extremity	ICD-10-CM	Diagnosis
I70.299	Other atherosclerosis of native arteries of extremities, unspecified extremity	ICD-10-CM	Diagnosis
I74	Arterial embolism and thrombosis	ICD-10-CM	Diagnosis
I74.0	Embolism and thrombosis of abdominal aorta	ICD-10-CM	Diagnosis
I74.01	Saddle embolus of abdominal aorta	ICD-10-CM	Diagnosis
I74.09	Other arterial embolism and thrombosis of abdominal aorta	ICD-10-CM	Diagnosis
I74.1	Embolism and thrombosis of other and unspecified parts of aorta	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I74.10	Embolism and thrombosis of unspecified parts of aorta	ICD-10-CM	Diagnosis
I74.11	Embolism and thrombosis of thoracic aorta	ICD-10-CM	Diagnosis
I74.19	Embolism and thrombosis of other parts of aorta	ICD-10-CM	Diagnosis
I74.2	Embolism and thrombosis of arteries of the upper extremities	ICD-10-CM	Diagnosis
I74.3	Embolism and thrombosis of arteries of the lower extremities	ICD-10-CM	Diagnosis
I74.4	Embolism and thrombosis of arteries of extremities, unspecified	ICD-10-CM	Diagnosis
I74.5	Embolism and thrombosis of iliac artery	ICD-10-CM	Diagnosis
I74.8	Embolism and thrombosis of other arteries	ICD-10-CM	Diagnosis
I74.9	Embolism and thrombosis of unspecified artery	ICD-10-CM	Diagnosis
I75	Atheroembolism	ICD-10-CM	Diagnosis
I75.0	Atheroembolism of extremities	ICD-10-CM	Diagnosis
I75.01	Atheroembolism of upper extremity	ICD-10-CM	Diagnosis
I75.011	Atheroembolism of right upper extremity	ICD-10-CM	Diagnosis
I75.012	Atheroembolism of left upper extremity	ICD-10-CM	Diagnosis
I75.013	Atheroembolism of bilateral upper extremities	ICD-10-CM	Diagnosis
I75.019	Atheroembolism of unspecified upper extremity	ICD-10-CM	Diagnosis
I75.02	Atheroembolism of lower extremity	ICD-10-CM	Diagnosis
I75.021	Atheroembolism of right lower extremity	ICD-10-CM	Diagnosis
I75.022	Atheroembolism of left lower extremity	ICD-10-CM	Diagnosis
I75.023	Atheroembolism of bilateral lower extremities	ICD-10-CM	Diagnosis
I75.029	Atheroembolism of unspecified lower extremity	ICD-10-CM	Diagnosis
I75.8	Atheroembolism of other sites	ICD-10-CM	Diagnosis
I75.81	Atheroembolism of kidney	ICD-10-CM	Diagnosis
I75.89	Atheroembolism of other site	ICD-10-CM	Diagnosis
T81.718A	Complication of other artery following a procedure, not elsewhere classified, initial encounter	ICD-10-CM	Diagnosis
T82.817A	Embolism due to cardiac prosthetic devices, implants and grafts, initial encounter	ICD-10-CM	Diagnosis
I70.26	Atherosclerosis of native arteries of extremities with gangrene	ICD-10-CM	Diagnosis
I70.261	Atherosclerosis of native arteries of extremities with gangrene, right leg	ICD-10-CM	Diagnosis
I70.262	Atherosclerosis of native arteries of extremities with gangrene, left leg	ICD-10-CM	Diagnosis
I70.263	Atherosclerosis of native arteries of extremities with gangrene, bilateral legs	ICD-10-CM	Diagnosis
I70.268	Atherosclerosis of native arteries of extremities with gangrene, other extremity	ICD-10-CM	Diagnosis
I70.269	Atherosclerosis of native arteries of extremities with gangrene, unspecified extremity	ICD-10-CM	Diagnosis
I70.36	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with gangrene	ICD-10-CM	Diagnosis
I70.361	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with gangrene, right leg	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
I70.362	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with gangrene, left leg	ICD-10-CM	Diagnosis
I70.363	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with gangrene, bilateral legs	ICD-10-CM	Diagnosis
I70.368	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with gangrene, other extremity	ICD-10-CM	Diagnosis
I70.369	Atherosclerosis of unspecified type of bypass graft(s) of the extremities with gangrene, unspecified extremity	ICD-10-CM	Diagnosis
I70.46	Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene	ICD-10-CM	Diagnosis
I70.461	Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene, right leg	ICD-10-CM	Diagnosis
I70.462	Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene, left leg	ICD-10-CM	Diagnosis
I70.463	Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene, bilateral legs	ICD-10-CM	Diagnosis
I70.468	Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene, other extremity	ICD-10-CM	Diagnosis
I70.469	Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene, unspecified extremity	ICD-10-CM	Diagnosis
I70.56	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with gangrene	ICD-10-CM	Diagnosis
I70.561	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with gangrene, right leg	ICD-10-CM	Diagnosis
I70.562	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with gangrene, left leg	ICD-10-CM	Diagnosis
I70.563	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with gangrene, bilateral legs	ICD-10-CM	Diagnosis
I70.568	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with gangrene, other extremity	ICD-10-CM	Diagnosis
I70.569	Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with gangrene, unspecified extremity	ICD-10-CM	Diagnosis
I70.66	Atherosclerosis of nonbiological bypass graft(s) of the extremities with gangrene	ICD-10-CM	Diagnosis
I70.661	Atherosclerosis of nonbiological bypass graft(s) of the extremities with gangrene, right leg	ICD-10-CM	Diagnosis
I70.662	Atherosclerosis of nonbiological bypass graft(s) of the extremities with gangrene, left leg	ICD-10-CM	Diagnosis
I70.663	Atherosclerosis of nonbiological bypass graft(s) of the extremities with gangrene, bilateral legs	ICD-10-CM	Diagnosis
I70.668	Atherosclerosis of nonbiological bypass graft(s) of the extremities with gangrene, other extremity	ICD-10-CM	Diagnosis
I70.669	Atherosclerosis of nonbiological bypass graft(s) of the extremities with gangrene, unspecified extremity	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I70.76	Atherosclerosis of other type of bypass graft(s) of the extremities with gangrene	ICD-10-CM	Diagnosis
I70.761	Atherosclerosis of other type of bypass graft(s) of the extremities with gangrene, right leg	ICD-10-CM	Diagnosis
I70.762	Atherosclerosis of other type of bypass graft(s) of the extremities with gangrene, left leg	ICD-10-CM	Diagnosis
I70.763	Atherosclerosis of other type of bypass graft(s) of the extremities with gangrene, bilateral legs	ICD-10-CM	Diagnosis
I70.768	Atherosclerosis of other type of bypass graft(s) of the extremities with gangrene, other extremity	ICD-10-CM	Diagnosis
I70.769	Atherosclerosis of other type of bypass graft(s) of the extremities with gangrene, unspecified extremity	ICD-10-CM	Diagnosis
I73.9	Peripheral vascular disease, unspecified	ICD-10-CM	Diagnosis
I73.8	Other specified peripheral vascular diseases	ICD-10-CM	Diagnosis
I73	Other peripheral vascular diseases	ICD-10-CM	Diagnosis
I73.89	Other specified peripheral vascular diseases	ICD-10-CM	Diagnosis
410.00	Acute myocardial infarction of anterolateral wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.01	Acute myocardial infarction of anterolateral wall, initial episode of care	ICD-9-CM	Diagnosis
410.02	Acute myocardial infarction of anterolateral wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.10	Acute myocardial infarction of other anterior wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.11	Acute myocardial infarction of other anterior wall, initial episode of care	ICD-9-CM	Diagnosis
410.12	Acute myocardial infarction of other anterior wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.20	Acute myocardial infarction of inferolateral wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.21	Acute myocardial infarction of inferolateral wall, initial episode of care	ICD-9-CM	Diagnosis
410.22	Acute myocardial infarction of inferolateral wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.30	Acute myocardial infarction of inferoposterior wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.31	Acute myocardial infarction of inferoposterior wall, initial episode of care	ICD-9-CM	Diagnosis
410.32	Acute myocardial infarction of inferoposterior wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.40	Acute myocardial infarction of other inferior wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.41	Acute myocardial infarction of other inferior wall, initial episode of care	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
410.42	Acute myocardial infarction of other inferior wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.50	Acute myocardial infarction of other lateral wall, episode of care unspecified	ICD-9-CM	Diagnosis
410.51	Acute myocardial infarction of other lateral wall, initial episode of care	ICD-9-CM	Diagnosis
410.52	Acute myocardial infarction of other lateral wall, subsequent episode of care	ICD-9-CM	Diagnosis
410.60	Acute myocardial infarction, true posterior wall infarction, episode of care unspecified	ICD-9-CM	Diagnosis
410.61	Acute myocardial infarction, true posterior wall infarction, initial episode of care	ICD-9-CM	Diagnosis
410.62	Acute myocardial infarction, true posterior wall infarction, subsequent episode of care	ICD-9-CM	Diagnosis
410.70	Acute myocardial infarction, subendocardial infarction, episode of care unspecified	ICD-9-CM	Diagnosis
410.71	Acute myocardial infarction, subendocardial infarction, initial episode of care	ICD-9-CM	Diagnosis
410.72	Acute myocardial infarction, subendocardial infarction, subsequent episode of care	ICD-9-CM	Diagnosis
410.80	Acute myocardial infarction of other specified sites, episode of care unspecified	ICD-9-CM	Diagnosis
410.81	Acute myocardial infarction of other specified sites, initial episode of care	ICD-9-CM	Diagnosis
410.82	Acute myocardial infarction of other specified sites, subsequent episode of care	ICD-9-CM	Diagnosis
410.90	Acute myocardial infarction, unspecified site, episode of care unspecified	ICD-9-CM	Diagnosis
410.91	Acute myocardial infarction, unspecified site, initial episode of care	ICD-9-CM	Diagnosis
410.92	Acute myocardial infarction, unspecified site, subsequent episode of care	ICD-9-CM	Diagnosis
411.1	Intermediate coronary syndrome	ICD-9-CM	Diagnosis
411.81	Acute coronary occlusion without myocardial infarction	ICD-9-CM	Diagnosis
411.89	Other acute and subacute form of ischemic heart disease	ICD-9-CM	Diagnosis
413.0	Angina decubitus	ICD-9-CM	Diagnosis
413.1	Prinzmetal angina	ICD-9-CM	Diagnosis
413.9	Other and unspecified angina pectoris	ICD-9-CM	Diagnosis
414.01	Coronary atherosclerosis of native coronary artery	ICD-9-CM	Diagnosis
414.02	Coronary atherosclerosis of autologous vein bypass graft	ICD-9-CM	Diagnosis
414.03	Coronary atherosclerosis of nonautologous biological bypass graft	ICD-9-CM	Diagnosis
414.04	Coronary atherosclerosis of artery bypass graft	ICD-9-CM	Diagnosis
414.05	Coronary atherosclerosis of unspecified type of bypass graft	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
414.06	Coronary atherosclerosis, of native coronary artery of transplanted heart	ICD-9-CM	Diagnosis
414.07	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart	ICD-9-CM	Diagnosis
414.3	Coronary atherosclerosis due to lipid rich plaque	ICD-9-CM	Diagnosis
414.4	Coronary atherosclerosis due to calcified coronary lesion	ICD-9-CM	Diagnosis
414.8	Other specified forms of chronic ischemic heart disease	ICD-9-CM	Diagnosis
415.11	Iatrogenic pulmonary embolism and infarction	ICD-9-CM	Diagnosis
427.1	Paroxysmal ventricular tachycardia	ICD-9-CM	Diagnosis
427.5	Cardiac arrest	ICD-9-CM	Diagnosis
429.79	Other certain sequelae of myocardial infarction, not elsewhere classified	ICD-9-CM	Diagnosis
430	Subarachnoid hemorrhage	ICD-9-CM	Diagnosis
431	Intracerebral hemorrhage	ICD-9-CM	Diagnosis
432.0	Nontraumatic extradural hemorrhage	ICD-9-CM	Diagnosis
432.1	Subdural hemorrhage	ICD-9-CM	Diagnosis
432.9	Unspecified intracranial hemorrhage	ICD-9-CM	Diagnosis
433.00	Occlusion and stenosis of basilar artery without mention of cerebral infarction	ICD-9-CM	Diagnosis
433.01	Occlusion and stenosis of basilar artery with cerebral infarction	ICD-9-CM	Diagnosis
433.10	Occlusion and stenosis of carotid artery without mention of cerebral infarction	ICD-9-CM	Diagnosis
433.11	Occlusion and stenosis of carotid artery with cerebral infarction	ICD-9-CM	Diagnosis
433.20	Occlusion and stenosis of vertebral artery without mention of cerebral infarction	ICD-9-CM	Diagnosis
433.21	Occlusion and stenosis of vertebral artery with cerebral infarction	ICD-9-CM	Diagnosis
433.30	Occlusion and stenosis of multiple and bilateral precerebral arteries without mention of cerebral infarction	ICD-9-CM	Diagnosis
433.31	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction	ICD-9-CM	Diagnosis
433.80	Occlusion and stenosis of other specified precerebral artery without mention of cerebral infarction	ICD-9-CM	Diagnosis
433.81	Occlusion and stenosis of other specified precerebral artery with cerebral infarction	ICD-9-CM	Diagnosis
433.90	Occlusion and stenosis of unspecified precerebral artery without mention of cerebral infarction	ICD-9-CM	Diagnosis
433.91	Occlusion and stenosis of unspecified precerebral artery with cerebral infarction	ICD-9-CM	Diagnosis
434.00	Cerebral thrombosis without mention of cerebral infarction	ICD-9-CM	Diagnosis
434.01	Cerebral thrombosis with cerebral infarction	ICD-9-CM	Diagnosis
434.10	Cerebral embolism without mention of cerebral infarction	ICD-9-CM	Diagnosis
434.11	Cerebral embolism with cerebral infarction	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
434.90	Unspecified cerebral artery occlusion without mention of cerebral infarction	ICD-9-CM	Diagnosis
434.91	Unspecified cerebral artery occlusion with cerebral infarction	ICD-9-CM	Diagnosis
435.0	Basilar artery syndrome	ICD-9-CM	Diagnosis
435.1	Vertebral artery syndrome	ICD-9-CM	Diagnosis
435.2	Subclavian steal syndrome	ICD-9-CM	Diagnosis
435.3	Vertebrobasilar artery syndrome	ICD-9-CM	Diagnosis
435.8	Other specified transient cerebral ischemias	ICD-9-CM	Diagnosis
435.9	Unspecified transient cerebral ischemia	ICD-9-CM	Diagnosis
436	Acute, but ill-defined, cerebrovascular disease	ICD-9-CM	Diagnosis
437.0	Cerebral atherosclerosis	ICD-9-CM	Diagnosis
437.1	Other generalized ischemic cerebrovascular disease	ICD-9-CM	Diagnosis
437.2	Hypertensive encephalopathy	ICD-9-CM	Diagnosis
437.3	Cerebral aneurysm, nonruptured	ICD-9-CM	Diagnosis
437.4	Cerebral arteritis	ICD-9-CM	Diagnosis
437.5	Moyamoya disease	ICD-9-CM	Diagnosis
437.8	Other ill-defined cerebrovascular disease	ICD-9-CM	Diagnosis
437.9	Unspecified cerebrovascular disease	ICD-9-CM	Diagnosis
438.0	Cognitive deficits due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.10	Unspecified speech and language deficit due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.11	Aphasia due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.12	Dysphasia due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.13	Late effects of cerebrovascular disease, speech and language deficits, dysarthria	ICD-9-CM	Diagnosis
438.14	Late effects of cerebrovascular disease, speech and language deficits, fluency disorder	ICD-9-CM	Diagnosis
438.19	Other speech and language deficits due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.20	Hemiplegia affecting unspecified side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.21	Hemiplegia affecting dominant side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.22	Hemiplegia affecting nondominant side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.30	Monoplegia of upper limb affecting unspecified side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.31	Monoplegia of upper limb affecting dominant side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.32	Monoplegia of upper limb affecting nondominant side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.40	Monoplegia of lower limb affecting unspecified side due to cerebrovascular disease	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
438.41	Monoplegia of lower limb affecting dominant side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.42	Monoplegia of lower limb affecting nondominant side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.50	Other paralytic syndrome affecting unspecified side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.51	Other paralytic syndrome affecting dominant side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.52	Other paralytic syndrome affecting nondominant side due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.6	Alteration of sensations as late effect of cerebrovascular disease	ICD-9-CM	Diagnosis
438.7	Disturbance of vision as late effect of cerebrovascular disease	ICD-9-CM	Diagnosis
438.81	Apraxia due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.82	Dysphagia due to cerebrovascular disease	ICD-9-CM	Diagnosis
438.83	Facial weakness as late effect of cerebrovascular disease	ICD-9-CM	Diagnosis
438.84	Ataxia as late effect of cerebrovascular disease	ICD-9-CM	Diagnosis
438.85	Vertigo as late effect of cerebrovascular disease	ICD-9-CM	Diagnosis
438.89	Other late effects of cerebrovascular disease	ICD-9-CM	Diagnosis
438.9	Unspecified late effects of cerebrovascular disease due to cerebrovascular disease	ICD-9-CM	Diagnosis
440.20	Atherosclerosis of native arteries of the extremities, unspecified	ICD-9-CM	Diagnosis
440.21	Atherosclerosis of native arteries of the extremities with intermittent claudication	ICD-9-CM	Diagnosis
440.22	Atherosclerosis of native arteries of the extremities with rest pain	ICD-9-CM	Diagnosis
440.23	Atherosclerosis of native arteries of the extremities with ulceration	ICD-9-CM	Diagnosis
440.29	Other atherosclerosis of native arteries of the extremities	ICD-9-CM	Diagnosis
440.30	Atherosclerosis of unspecified bypass graft of extremities	ICD-9-CM	Diagnosis
440.31	Atherosclerosis of autologous vein bypass graft of extremities	ICD-9-CM	Diagnosis
440.32	Atherosclerosis of nonautologous biological bypass graft of extremities	ICD-9-CM	Diagnosis
440.4	Chronic total occlusion of artery of the extremities	ICD-9-CM	Diagnosis
443.81	Peripheral angiopathy in diseases classified elsewhere	ICD-9-CM	Diagnosis
443.89	Other peripheral vascular disease	ICD-9-CM	Diagnosis
443.9	Unspecified peripheral vascular disease	ICD-9-CM	Diagnosis
444.01	Saddle embolus of abdominal aorta	ICD-9-CM	Diagnosis
444.09	Other arterial embolism and thrombosis of abdominal aorta	ICD-9-CM	Diagnosis
444.1	Embolism and thrombosis of thoracic aorta	ICD-9-CM	Diagnosis
444.21	Embolism and thrombosis of arteries of upper extremity	ICD-9-CM	Diagnosis
444.22	Embolism and thrombosis of arteries of lower extremity	ICD-9-CM	Diagnosis
444.81	Embolism and thrombosis of iliac artery	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
444.89	Embolism and thrombosis of other specified artery	ICD-9-CM	Diagnosis
444.9	Embolism and thrombosis of unspecified artery	ICD-9-CM	Diagnosis
445.01	Atheroembolism of upper extremity	ICD-9-CM	Diagnosis
445.02	Atheroembolism of lower extremity	ICD-9-CM	Diagnosis
445.81	Atheroembolism of kidney	ICD-9-CM	Diagnosis
445.89	Atheroembolism of other site	ICD-9-CM	Diagnosis
996.71	Other complications due to heart valve prosthesis	ICD-9-CM	Diagnosis
996.72	Other complications due to other cardiac device, implant, and graft	ICD-9-CM	Diagnosis
997.2	Peripheral vascular complications	ICD-9-CM	Diagnosis
997.79	Vascular complications of other vessels	ICD-9-CM	Diagnosis
V45.81	Postprocedural aortocoronary bypass status	ICD-9-CM	Diagnosis
V45.82	Postprocedural percutaneous transluminal coronary angioplasty status	ICD-9-CM	Diagnosis
C1034	Catheter, coronary angioplasty, surpass superfusion catheter, long 30 surpass superfusion catheter	HCPCS	Procedure
C1100	Guide wire, percutaneous transluminal coronary angioplasty, medtronic ave gt1 guide wire, medtronic ave gt2 fusion guide wire, interventional technologies trackwire, interventional technologies trackwire support, interventional technologies trackwire extra support	HCPCS	Procedure
C1101	Catheter, percutaneous transluminal coronary angioplasty guide, medtronic ave 5f, 6f, 7f, 8f, 9f zuma guide catheter, medtronic ave z2 5f, 6f, 7f, 8f, 9f zuma guide catheter, medtronic ave vector guide catheter, medtronic ave vector x guide catheter. note: only the medtronic ave z2 zuma guide catheters are effective october 1, 2000. the medtronic ave zuma guide catheters were effective august 1, 2000.	HCPCS	Procedure
C1366	Guide wire, percutaneous transluminal coronary angioplasty, hi-torque iron man, hi-torque balance middleweight, hi-torque all star, hi-torque balance heavyweight, hi-torque balance trek	HCPCS	Procedure
C1367	Guide wire, percutaneous transluminal coronary angioplasty, hi-torque cross it, hi-torque cross-it 100xt, hi-torque cross-it 200xt, hi-torque cross-it 300xt, hi-torque wiggle	HCPCS	Procedure
C1500	Atherectomy system, peripheral, rotablator rotational angioplasty system with rotalink exchangeable catheter, advancer, and guide wire	HCPCS	Procedure
C1725	Catheter, transluminal angioplasty, nonlaser (may include guidance, infusion/perfusion capability)	HCPCS	Procedure
C1885	Catheter, transluminal angioplasty, laser	HCPCS	Procedure
C1930	Catheter, percutaneous transluminal coronary angioplasty, coyote dilatation catheter 20mm/30mm/40mm	HCPCS	Procedure

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Code	Description	Code Type	Code Category
C1933	Catheter, opti-plast centurion 5.5f pta catheter (shaft length 50 cm to 120 cm), opti-plast xl 5.5f pta catheter (shaft length 75 cm to 120 cm), opti-plast pta catheter (5.5 fr), tru trac 5fr percutaneous transluminal angioplasty balloon dilatation catheter, optiplast xt 5 fr percutaneous transluminal angioplasty catheter (various sizes)	HCPCS	Procedure
C1948	Catheter, pursuit balloon angioplasty catheter, cook accent balloon angioplasty catheter	HCPCS	Procedure
C1981	Catheter ,coronary angioplasty balloon, adante, bonnie, bonnie 15mm, bonnie monorail 30mm or 40mm, bonnie sliding rail, bypass speedy, chubby, chubby sliding rail, coyote 20mm, coyote 9/15/25mm, maxxum, nc ranger, nc ranger 9mm, ranger 20mm, long ranger 30mm or 40mm, nc ranger 16/18mm, nc ranger 22/25/30mm, nc big ranger, quantum ranger, quantum ranger 1/4 sizes, quantum ranger 9/16/18mm, quantum ranger 22/30mm, quantum ranger 25mm, ranger lp 20/30/40, viva/long viva, ace - 1cm, ace - 2cm, ace graft, long ace, pivot cobra (10, 14, 18, 30, 40mm in lengths) note: only the bonnie monorail 30mm or 40mm, long ranger 30mm or 40mm, and ranger 20mm are effective 01/01/01. the other catheters were effective 08/01/00.	HCPCS	Procedure
C2605	Catheter, spectranetics extreme laser catheter, spectranetics extreme 0.9mm coronary angioplasty catheter (model 110-001)	HCPCS	Procedure
C2623	Catheter, transluminal angioplasty, drug-coated, nonlaser	HCPCS	Procedure
C3551	Guide wire, percutaneous transluminal coronary angioplasty, choice, luge, patriot, pt graphix intermediate, trooper, mailman 182/300 cm, glidewire gold guidewire, platinum plus guidewire, platinum plus guidewire with glidex hydrophilic coating, jagwire single-use high performance guide wire, merit medical systems extender guidewire, merit medical systems tomcat ptca guidewire, platinum plus guidewire (0.014 and 0.018 in diameters)	HCPCS	Procedure
C8526	Optiplast xt 5f percutaneous transluminal angioplasty catheter (various sizes)	HCPCS	Procedure
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	HCPCS	Procedure
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	HCPCS	Procedure

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Code	Description	Code Type	Code Category
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	HCPCS	Procedure
C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	HCPCS	Procedure
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	HCPCS	Procedure
C9605	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)	HCPCS	Procedure
C9606	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	HCPCS	Procedure
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	HCPCS	Procedure
C9608	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)	HCPCS	Procedure
G0290	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	HCPCS	Procedure
G0291	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel	HCPCS	Procedure

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Code	Description	Code Type	Code Category
S2205	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using arterial graft(s), single coronary arterial graft	HCPCS	Procedure
S2206	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using arterial graft(s), 2 coronary arterial grafts	HCPCS	Procedure
S2207	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using venous graft only, single coronary venous graft	HCPCS	Procedure
S2208	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using single arterial and venous graft(s), single venous graft	HCPCS	Procedure
S2209	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using 2 arterial grafts and single venous graft	HCPCS	Procedure
00.40	Procedure on single vessel	ICD-9-CM	Procedure
00.41	Procedure on two vessels	ICD-9-CM	Procedure
00.42	Procedure on three vessels	ICD-9-CM	Procedure
00.43	Procedure on four or more vessels	ICD-9-CM	Procedure
00.44	Procedure on vessel bifurcation	ICD-9-CM	Procedure
00.45	Insertion of one vascular stent	ICD-9-CM	Procedure
00.46	Insertion of two vascular stents	ICD-9-CM	Procedure
00.47	Insertion of three vascular stents	ICD-9-CM	Procedure
00.48	Insertion of four or more vascular stents	ICD-9-CM	Procedure
00.66	Percutaneous transluminal coronary angioplasty [PTCA]	ICD-9-CM	Procedure
17.55	Transluminal coronary atherectomy	ICD-9-CM	Procedure
36.03	Open chest coronary artery angioplasty	ICD-9-CM	Procedure
36.04	Intracoronary artery thrombolytic infusion	ICD-9-CM	Procedure
36.06	Insertion of non-drug-eluting coronary artery stent(s)	ICD-9-CM	Procedure
36.07	Insertion of drug-eluting coronary artery stent(s)	ICD-9-CM	Procedure
36.09	Other removal of coronary artery obstruction	ICD-9-CM	Procedure
36.10	Aortocoronary bypass for heart revascularization, not otherwise specified	ICD-9-CM	Procedure
36.11	(Aorto)coronary bypass of one coronary artery	ICD-9-CM	Procedure
36.12	(Aorto)coronary bypass of two coronary arteries	ICD-9-CM	Procedure
36.13	(Aorto)coronary bypass of three coronary arteries	ICD-9-CM	Procedure
36.14	(Aorto)coronary bypass of four or more coronary arteries	ICD-9-CM	Procedure
36.15	Single internal mammary-coronary artery bypass	ICD-9-CM	Procedure
36.16	Double internal mammary-coronary artery bypass	ICD-9-CM	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
36.17	Abdominal-coronary artery bypass	ICD-9-CM	Procedure
36.19	Other bypass anastomosis for heart revascularization	ICD-9-CM	Procedure
36.2	Heart revascularization by arterial implant	ICD-9-CM	Procedure
92.27	Implantation or insertion of radioactive elements	ICD-9-CM	Procedure
0210083	Bypass Coronary Artery, One Artery from Coronary Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0210088	Bypass Coronary Artery, One Artery from Right Internal Mammary with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0210089	Bypass Coronary Artery, One Artery from Left Internal Mammary with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0210093	Bypass Coronary Artery, One Artery from Coronary Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0210098	Bypass Coronary Artery, One Artery from Right Internal Mammary with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0210099	Bypass Coronary Artery, One Artery from Left Internal Mammary with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0210483	Bypass Coronary Artery, One Artery from Coronary Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0210488	Bypass Coronary Artery, One Artery from Right Internal Mammary with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0210489	Bypass Coronary Artery, One Artery from Left Internal Mammary with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0210493	Bypass Coronary Artery, One Artery from Coronary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0210498	Bypass Coronary Artery, One Artery from Right Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0210499	Bypass Coronary Artery, One Artery from Left Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0211083	Bypass Coronary Artery, Two Arteries from Coronary Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0211088	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0211089	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0211093	Bypass Coronary Artery, Two Arteries from Coronary Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0211098	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
0211099	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0211483	Bypass Coronary Artery, Two Arteries from Coronary Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0211488	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0211489	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0211493	Bypass Coronary Artery, Two Arteries from Coronary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0211498	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0211499	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0212083	Bypass Coronary Artery, Three Arteries from Coronary Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0212088	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0212089	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0212093	Bypass Coronary Artery, Three Arteries from Coronary Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0212098	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0212099	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0212483	Bypass Coronary Artery, Three Arteries from Coronary Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0212488	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0212489	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0212493	Bypass Coronary Artery, Three Arteries from Coronary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
0212498	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0212499	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0213083	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0213088	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0213089	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
0213093	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0213098	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0213099	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
0213483	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0213488	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0213489	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0213493	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0213498	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0213499	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0270046	Dilation of Coronary Artery, One Artery, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
0270056	Dilation of Coronary Artery, One Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0270066	Dilation of Coronary Artery, One Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
0270076	Dilation of Coronary Artery, One Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0270346	Dilation of Coronary Artery, One Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
0270356	Dilation of Coronary Artery, One Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0270366	Dilation of Coronary Artery, One Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0270376	Dilation of Coronary Artery, One Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0270446	Dilation of Coronary Artery, One Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0270456	Dilation of Coronary Artery, One Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0270466	Dilation of Coronary Artery, One Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0270476	Dilation of Coronary Artery, One Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0271046	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
0271056	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Two Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0271066	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Three Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0271076	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0271346	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
0271356	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0271366	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0271376	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
0271446	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0271456	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0271466	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0271476	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0272046	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
0272056	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Two Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0272066	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Three Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0272076	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0272346	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
0272356	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0272366	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0272376	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0272446	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0272456	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0272466	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0272476	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
0273046	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
0273056	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Two Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0273066	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Three Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0273076	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
0273346	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
0273356	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0273366	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0273376	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
0273446	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0273456	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0273466	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
0273476	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02700E6	Dilation of Coronary Artery, One Artery, Bifurcation, with Two Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02703E6	Dilation of Coronary Artery, One Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02704E6	Dilation of Coronary Artery, One Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02710E6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Two Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02713E6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02714E6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
02720E6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Two Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02723E6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02724E6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02730E6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Two Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02733E6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02734E6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021008C	Bypass Coronary Artery, One Artery from Thoracic Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021008F	Bypass Coronary Artery, One Artery from Abdominal Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021008W	Bypass Coronary Artery, One Artery from Aorta with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021009C	Bypass Coronary Artery, One Artery from Thoracic Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021009F	Bypass Coronary Artery, One Artery from Abdominal Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021009W	Bypass Coronary Artery, One Artery from Aorta with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
02100A3	Bypass Coronary Artery, One Artery from Coronary Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02100A8	Bypass Coronary Artery, One Artery from Right Internal Mammary with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02100A9	Bypass Coronary Artery, One Artery from Left Internal Mammary with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02100AC	Bypass Coronary Artery, One Artery from Thoracic Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02100AF	Bypass Coronary Artery, One Artery from Abdominal Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02100AW	Bypass Coronary Artery, One Artery from Aorta with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02100J3	Bypass Coronary Artery, One Artery from Coronary Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02100J8	Bypass Coronary Artery, One Artery from Right Internal Mammary with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02100J9	Bypass Coronary Artery, One Artery from Left Internal Mammary with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
02100JC	Bypass Coronary Artery, One Artery from Thoracic Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02100JF	Bypass Coronary Artery, One Artery from Abdominal Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02100JW	Bypass Coronary Artery, One Artery from Aorta with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02100K3	Bypass Coronary Artery, One Artery from Coronary Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02100K8	Bypass Coronary Artery, One Artery from Right Internal Mammary with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02100K9	Bypass Coronary Artery, One Artery from Left Internal Mammary with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02100KC	Bypass Coronary Artery, One Artery from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02100KF	Bypass Coronary Artery, One Artery from Abdominal Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02100KW	Bypass Coronary Artery, One Artery from Aorta with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02100Z3	Bypass Coronary Artery, One Artery from Coronary Artery, Open Approach	ICD-10-PCS	Procedure
02100Z8	Bypass Coronary Artery, One Artery from Right Internal Mammary, Open Approach	ICD-10-PCS	Procedure
02100Z9	Bypass Coronary Artery, One Artery from Left Internal Mammary, Open Approach	ICD-10-PCS	Procedure
02100ZC	Bypass Coronary Artery, One Artery from Thoracic Artery, Open Approach	ICD-10-PCS	Procedure
02100ZF	Bypass Coronary Artery, One Artery from Abdominal Artery, Open Approach	ICD-10-PCS	Procedure
021048C	Bypass Coronary Artery, One Artery from Thoracic Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021048F	Bypass Coronary Artery, One Artery from Abdominal Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021048W	Bypass Coronary Artery, One Artery from Aorta with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021049C	Bypass Coronary Artery, One Artery from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021049F	Bypass Coronary Artery, One Artery from Abdominal Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
021049W	Bypass Coronary Artery, One Artery from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104A3	Bypass Coronary Artery, One Artery from Coronary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104A8	Bypass Coronary Artery, One Artery from Right Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104A9	Bypass Coronary Artery, One Artery from Left Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104AC	Bypass Coronary Artery, One Artery from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104AF	Bypass Coronary Artery, One Artery from Abdominal Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104AW	Bypass Coronary Artery, One Artery from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104J3	Bypass Coronary Artery, One Artery from Coronary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104J8	Bypass Coronary Artery, One Artery from Right Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104J9	Bypass Coronary Artery, One Artery from Left Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104JC	Bypass Coronary Artery, One Artery from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104JF	Bypass Coronary Artery, One Artery from Abdominal Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104JW	Bypass Coronary Artery, One Artery from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104K3	Bypass Coronary Artery, One Artery from Coronary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104K8	Bypass Coronary Artery, One Artery from Right Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104K9	Bypass Coronary Artery, One Artery from Left Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02104KC	Bypass Coronary Artery, One Artery from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104KF	Bypass Coronary Artery, One Artery from Abdominal Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104KW	Bypass Coronary Artery, One Artery from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104Z3	Bypass Coronary Artery, One Artery from Coronary Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104Z8	Bypass Coronary Artery, One Artery from Right Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104Z9	Bypass Coronary Artery, One Artery from Left Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104ZC	Bypass Coronary Artery, One Artery from Thoracic Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02104ZF	Bypass Coronary Artery, One Artery from Abdominal Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021108C	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021108F	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021108W	Bypass Coronary Artery, Two Arteries from Aorta with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021109C	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021109F	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021109W	Bypass Coronary Artery, Two Arteries from Aorta with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
02110A3	Bypass Coronary Artery, Two Arteries from Coronary Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02110A8	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02110A9	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02110AC	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02110AF	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02110AW	Bypass Coronary Artery, Two Arteries from Aorta with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02110J3	Bypass Coronary Artery, Two Arteries from Coronary Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02110J8	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02110J9	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02110JC	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02110JF	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02110JW	Bypass Coronary Artery, Two Arteries from Aorta with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02110K3	Bypass Coronary Artery, Two Arteries from Coronary Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02110K8	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02110K9	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02110KC	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02110KF	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02110KW	Bypass Coronary Artery, Two Arteries from Aorta with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02110Z3	Bypass Coronary Artery, Two Arteries from Coronary Artery, Open Approach	ICD-10-PCS	Procedure
02110Z8	Bypass Coronary Artery, Two Arteries from Right Internal Mammary, Open Approach	ICD-10-PCS	Procedure
02110Z9	Bypass Coronary Artery, Two Arteries from Left Internal Mammary, Open Approach	ICD-10-PCS	Procedure
02110ZC	Bypass Coronary Artery, Two Arteries from Thoracic Artery, Open Approach	ICD-10-PCS	Procedure
02110ZF	Bypass Coronary Artery, Two Arteries from Abdominal Artery, Open Approach	ICD-10-PCS	Procedure
021148C	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021148F	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021148W	Bypass Coronary Artery, Two Arteries from Aorta with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
021149C	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021149F	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021149W	Bypass Coronary Artery, Two Arteries from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114A3	Bypass Coronary Artery, Two Arteries from Coronary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114A8	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114A9	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114AC	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114AF	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114AW	Bypass Coronary Artery, Two Arteries from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114J3	Bypass Coronary Artery, Two Arteries from Coronary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114J8	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114J9	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114JC	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114JF	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114JW	Bypass Coronary Artery, Two Arteries from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114K3	Bypass Coronary Artery, Two Arteries from Coronary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02114K8	Bypass Coronary Artery, Two Arteries from Right Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114K9	Bypass Coronary Artery, Two Arteries from Left Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114KC	Bypass Coronary Artery, Two Arteries from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114KF	Bypass Coronary Artery, Two Arteries from Abdominal Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114KW	Bypass Coronary Artery, Two Arteries from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114Z3	Bypass Coronary Artery, Two Arteries from Coronary Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114Z8	Bypass Coronary Artery, Two Arteries from Right Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114Z9	Bypass Coronary Artery, Two Arteries from Left Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114ZC	Bypass Coronary Artery, Two Arteries from Thoracic Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02114ZF	Bypass Coronary Artery, Two Arteries from Abdominal Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021208C	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021208F	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021208W	Bypass Coronary Artery, Three Arteries from Aorta with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021209C	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021209F	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021209W	Bypass Coronary Artery, Three Arteries from Aorta with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
02120A3	Bypass Coronary Artery, Three Arteries from Coronary Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02120A8	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02120A9	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02120AC	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02120AF	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02120AW	Bypass Coronary Artery, Three Arteries from Aorta with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02120J3	Bypass Coronary Artery, Three Arteries from Coronary Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02120J8	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02120J9	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02120JC	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02120JF	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02120JW	Bypass Coronary Artery, Three Arteries from Aorta with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02120K3	Bypass Coronary Artery, Three Arteries from Coronary Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02120K8	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02120K9	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02120KC	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02120KF	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02120KW	Bypass Coronary Artery, Three Arteries from Aorta with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02120Z3	Bypass Coronary Artery, Three Arteries from Coronary Artery, Open Approach	ICD-10-PCS	Procedure
02120Z8	Bypass Coronary Artery, Three Arteries from Right Internal Mammary, Open Approach	ICD-10-PCS	Procedure
02120Z9	Bypass Coronary Artery, Three Arteries from Left Internal Mammary, Open Approach	ICD-10-PCS	Procedure
02120ZC	Bypass Coronary Artery, Three Arteries from Thoracic Artery, Open Approach	ICD-10-PCS	Procedure
02120ZF	Bypass Coronary Artery, Three Arteries from Abdominal Artery, Open Approach	ICD-10-PCS	Procedure
021248C	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
021248F	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021248W	Bypass Coronary Artery, Three Arteries from Aorta with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021249C	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021249F	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021249W	Bypass Coronary Artery, Three Arteries from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124A3	Bypass Coronary Artery, Three Arteries from Coronary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124A8	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124A9	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124AC	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124AF	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124AW	Bypass Coronary Artery, Three Arteries from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124J3	Bypass Coronary Artery, Three Arteries from Coronary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124J8	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124J9	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124JC	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124JF	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02124JW	Bypass Coronary Artery, Three Arteries from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124K3	Bypass Coronary Artery, Three Arteries from Coronary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124K8	Bypass Coronary Artery, Three Arteries from Right Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124K9	Bypass Coronary Artery, Three Arteries from Left Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124KC	Bypass Coronary Artery, Three Arteries from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124KF	Bypass Coronary Artery, Three Arteries from Abdominal Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124KW	Bypass Coronary Artery, Three Arteries from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124Z3	Bypass Coronary Artery, Three Arteries from Coronary Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124Z8	Bypass Coronary Artery, Three Arteries from Right Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124Z9	Bypass Coronary Artery, Three Arteries from Left Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124ZC	Bypass Coronary Artery, Three Arteries from Thoracic Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02124ZF	Bypass Coronary Artery, Three Arteries from Abdominal Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021308C	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021308F	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021308W	Bypass Coronary Artery, Four or More Arteries from Aorta with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021309C	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021309F	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021309W	Bypass Coronary Artery, Four or More Arteries from Aorta with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
02130A3	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02130A8	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02130A9	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02130AC	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02130AF	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02130AW	Bypass Coronary Artery, Four or More Arteries from Aorta with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
02130J3	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02130J8	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02130J9	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02130JC	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02130JF	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02130JW	Bypass Coronary Artery, Four or More Arteries from Aorta with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
02130K3	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02130K8	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02130K9	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02130KC	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02130KF	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02130KW	Bypass Coronary Artery, Four or More Arteries from Aorta with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
02130Z3	Bypass Coronary Artery, Four or More Arteries from Coronary Artery, Open Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02130Z8	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary, Open Approach	ICD-10-PCS	Procedure
02130Z9	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary, Open Approach	ICD-10-PCS	Procedure
02130ZC	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery, Open Approach	ICD-10-PCS	Procedure
02130ZF	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery, Open Approach	ICD-10-PCS	Procedure
021348C	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021348F	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021348W	Bypass Coronary Artery, Four or More Arteries from Aorta with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021349C	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021349F	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021349W	Bypass Coronary Artery, Four or More Arteries from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134A3	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134A8	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134A9	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134AC	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134AF	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134AW	Bypass Coronary Artery, Four or More Arteries from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02134J3	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134J8	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134J9	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134JC	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134JF	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134JW	Bypass Coronary Artery, Four or More Arteries from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134K3	Bypass Coronary Artery, Four or More Arteries from Coronary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134K8	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134K9	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134KC	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134KF	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134KW	Bypass Coronary Artery, Four or More Arteries from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134Z3	Bypass Coronary Artery, Four or More Arteries from Coronary Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134Z8	Bypass Coronary Artery, Four or More Arteries from Right Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134Z9	Bypass Coronary Artery, Four or More Arteries from Left Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02134ZC	Bypass Coronary Artery, Four or More Arteries from Thoracic Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02134ZF	Bypass Coronary Artery, Four or More Arteries from Abdominal Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021K0Z8	Bypass Right Ventricle to Right Internal Mammary, Open Approach	ICD-10-PCS	Procedure
021K0Z9	Bypass Right Ventricle to Left Internal Mammary, Open Approach	ICD-10-PCS	Procedure
021K0ZC	Bypass Right Ventricle to Thoracic Artery, Open Approach	ICD-10-PCS	Procedure
021K0ZF	Bypass Right Ventricle to Abdominal Artery, Open Approach	ICD-10-PCS	Procedure
021K0ZW	Bypass Right Ventricle to Aorta, Open Approach	ICD-10-PCS	Procedure
021K4Z8	Bypass Right Ventricle to Right Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021K4Z9	Bypass Right Ventricle to Left Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021K4ZC	Bypass Right Ventricle to Thoracic Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021K4ZF	Bypass Right Ventricle to Abdominal Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021K4ZW	Bypass Right Ventricle to Aorta, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L08P	Bypass Left Ventricle to Pulmonary Trunk with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021L08Q	Bypass Left Ventricle to Right Pulmonary Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021L08R	Bypass Left Ventricle to Left Pulmonary Artery with Zooplastic Tissue, Open Approach	ICD-10-PCS	Procedure
021L09P	Bypass Left Ventricle to Pulmonary Trunk with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021L09Q	Bypass Left Ventricle to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021L09R	Bypass Left Ventricle to Left Pulmonary Artery with Autologous Venous Tissue, Open Approach	ICD-10-PCS	Procedure
021L0AP	Bypass Left Ventricle to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
021L0AQ	Bypass Left Ventricle to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
021L0AR	Bypass Left Ventricle to Left Pulmonary Artery with Autologous Arterial Tissue, Open Approach	ICD-10-PCS	Procedure
021L0JP	Bypass Left Ventricle to Pulmonary Trunk with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
021L0JQ	Bypass Left Ventricle to Right Pulmonary Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure
021L0JR	Bypass Left Ventricle to Left Pulmonary Artery with Synthetic Substitute, Open Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
021L0KP	Bypass Left Ventricle to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
021L0KQ	Bypass Left Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
021L0KR	Bypass Left Ventricle to Left Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach	ICD-10-PCS	Procedure
021L0Z8	Bypass Left Ventricle to Right Internal Mammary, Open Approach	ICD-10-PCS	Procedure
021L0Z9	Bypass Left Ventricle to Left Internal Mammary, Open Approach	ICD-10-PCS	Procedure
021L0ZC	Bypass Left Ventricle to Thoracic Artery, Open Approach	ICD-10-PCS	Procedure
021L0ZF	Bypass Left Ventricle to Abdominal Artery, Open Approach	ICD-10-PCS	Procedure
021L0ZP	Bypass Left Ventricle to Pulmonary Trunk, Open Approach	ICD-10-PCS	Procedure
021L0ZQ	Bypass Left Ventricle to Right Pulmonary Artery, Open Approach	ICD-10-PCS	Procedure
021L0ZR	Bypass Left Ventricle to Left Pulmonary Artery, Open Approach	ICD-10-PCS	Procedure
021L48P	Bypass Left Ventricle to Pulmonary Trunk with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L48Q	Bypass Left Ventricle to Right Pulmonary Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L48R	Bypass Left Ventricle to Left Pulmonary Artery with Zooplastic Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L49P	Bypass Left Ventricle to Pulmonary Trunk with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L49Q	Bypass Left Ventricle to Right Pulmonary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L49R	Bypass Left Ventricle to Left Pulmonary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4AP	Bypass Left Ventricle to Pulmonary Trunk with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4AQ	Bypass Left Ventricle to Right Pulmonary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4AR	Bypass Left Ventricle to Left Pulmonary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4JP	Bypass Left Ventricle to Pulmonary Trunk with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4JQ	Bypass Left Ventricle to Right Pulmonary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4JR	Bypass Left Ventricle to Left Pulmonary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
021L4KP	Bypass Left Ventricle to Pulmonary Trunk with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4KQ	Bypass Left Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4KR	Bypass Left Ventricle to Left Pulmonary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4Z8	Bypass Left Ventricle to Right Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4Z9	Bypass Left Ventricle to Left Internal Mammary, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4ZC	Bypass Left Ventricle to Thoracic Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4ZF	Bypass Left Ventricle to Abdominal Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4ZP	Bypass Left Ventricle to Pulmonary Trunk, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4ZQ	Bypass Left Ventricle to Right Pulmonary Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
021L4ZR	Bypass Left Ventricle to Left Pulmonary Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027004Z	Dilation of Coronary Artery, One Artery with Drug-eluting Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
027005Z	Dilation of Coronary Artery, One Artery with Two Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
027006Z	Dilation of Coronary Artery, One Artery with Three Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
027007Z	Dilation of Coronary Artery, One Artery with Four or More Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02700D6	Dilation of Coronary Artery, One Artery, Bifurcation, with Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02700DZ	Dilation of Coronary Artery, One Artery with Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02700EZ	Dilation of Coronary Artery, One Artery with Two Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02700F6	Dilation of Coronary Artery, One Artery, Bifurcation, with Three Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02700FZ	Dilation of Coronary Artery, One Artery with Three Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02700G6	Dilation of Coronary Artery, One Artery, Bifurcation, with Four or More Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02700GZ	Dilation of Coronary Artery, One Artery with Four or More Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02700T6	Dilation of Coronary Artery, One Artery, Bifurcation, with Radioactive Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02700TZ	Dilation of Coronary Artery, One Artery with Radioactive Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02700Z6	Dilation of Coronary Artery, One Artery, Bifurcation, Open Approach	ICD-10-PCS	Procedure
02700ZZ	Dilation of Coronary Artery, One Artery, Open Approach	ICD-10-PCS	Procedure
027034Z	Dilation of Coronary Artery, One Artery with Drug-eluting Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
027035Z	Dilation of Coronary Artery, One Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
027036Z	Dilation of Coronary Artery, One Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
027037Z	Dilation of Coronary Artery, One Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02703D6	Dilation of Coronary Artery, One Artery, Bifurcation, with Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02703DZ	Dilation of Coronary Artery, One Artery with Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02703EZ	Dilation of Coronary Artery, One Artery with Two Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02703F6	Dilation of Coronary Artery, One Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02703FZ	Dilation of Coronary Artery, One Artery with Three Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02703G6	Dilation of Coronary Artery, One Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02703GZ	Dilation of Coronary Artery, One Artery with Four or More Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02703T6	Dilation of Coronary Artery, One Artery, Bifurcation, with Radioactive Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02703TZ	Dilation of Coronary Artery, One Artery with Radioactive Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
027044Z	Dilation of Coronary Artery, One Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027045Z	Dilation of Coronary Artery, One Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027046Z	Dilation of Coronary Artery, One Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027047Z	Dilation of Coronary Artery, One Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02704D6	Dilation of Coronary Artery, One Artery, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02704DZ	Dilation of Coronary Artery, One Artery with Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02704EZ	Dilation of Coronary Artery, One Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02704F6	Dilation of Coronary Artery, One Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02704FZ	Dilation of Coronary Artery, One Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02704G6	Dilation of Coronary Artery, One Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02704GZ	Dilation of Coronary Artery, One Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02704T6	Dilation of Coronary Artery, One Artery, Bifurcation, with Radioactive Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02704TZ	Dilation of Coronary Artery, One Artery with Radioactive Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027104Z	Dilation of Coronary Artery, Two Arteries with Drug-eluting Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
027105Z	Dilation of Coronary Artery, Two Arteries with Two Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
027106Z	Dilation of Coronary Artery, Two Arteries with Three Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
027107Z	Dilation of Coronary Artery, Two Arteries with Four or More Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02710D6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02710DZ	Dilation of Coronary Artery, Two Arteries with Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02710EZ	Dilation of Coronary Artery, Two Arteries with Two Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02710F6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Three Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02710FZ	Dilation of Coronary Artery, Two Arteries with Three Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02710G6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Four or More Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02710GZ	Dilation of Coronary Artery, Two Arteries with Four or More Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02710T6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Radioactive Intraluminal Device, Open Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02710TZ	Dilation of Coronary Artery, Two Arteries with Radioactive Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02710Z6	Dilation of Coronary Artery, Two Arteries, Bifurcation, Open Approach	ICD-10-PCS	Procedure
02710ZZ	Dilation of Coronary Artery, Two Arteries, Open Approach	ICD-10-PCS	Procedure
027134Z	Dilation of Coronary Artery, Two Arteries with Drug-eluting Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
027135Z	Dilation of Coronary Artery, Two Arteries with Two Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
027136Z	Dilation of Coronary Artery, Two Arteries with Three Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
027137Z	Dilation of Coronary Artery, Two Arteries with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02713D6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02713DZ	Dilation of Coronary Artery, Two Arteries with Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02713EZ	Dilation of Coronary Artery, Two Arteries with Two Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02713F6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02713FZ	Dilation of Coronary Artery, Two Arteries with Three Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02713G6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02713GZ	Dilation of Coronary Artery, Two Arteries with Four or More Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02713T6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Radioactive Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02713TZ	Dilation of Coronary Artery, Two Arteries with Radioactive Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
027144Z	Dilation of Coronary Artery, Two Arteries with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027145Z	Dilation of Coronary Artery, Two Arteries with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027146Z	Dilation of Coronary Artery, Two Arteries with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027147Z	Dilation of Coronary Artery, Two Arteries with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02714D6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02714DZ	Dilation of Coronary Artery, Two Arteries with Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02714EZ	Dilation of Coronary Artery, Two Arteries with Two Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02714F6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02714FZ	Dilation of Coronary Artery, Two Arteries with Three Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02714G6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02714GZ	Dilation of Coronary Artery, Two Arteries with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02714T6	Dilation of Coronary Artery, Two Arteries, Bifurcation, with Radioactive Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02714TZ	Dilation of Coronary Artery, Two Arteries with Radioactive Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027204Z	Dilation of Coronary Artery, Three Arteries with Drug-eluting Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
027205Z	Dilation of Coronary Artery, Three Arteries with Two Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
027206Z	Dilation of Coronary Artery, Three Arteries with Three Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
027207Z	Dilation of Coronary Artery, Three Arteries with Four or More Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02720D6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02720DZ	Dilation of Coronary Artery, Three Arteries with Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02720EZ	Dilation of Coronary Artery, Three Arteries with Two Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02720F6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Three Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02720FZ	Dilation of Coronary Artery, Three Arteries with Three Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02720G6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Four or More Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02720GZ	Dilation of Coronary Artery, Three Arteries with Four or More Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02720T6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Radioactive Intraluminal Device, Open Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02720TZ	Dilation of Coronary Artery, Three Arteries with Radioactive Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02720Z6	Dilation of Coronary Artery, Three Arteries, Bifurcation, Open Approach	ICD-10-PCS	Procedure
02720ZZ	Dilation of Coronary Artery, Three Arteries, Open Approach	ICD-10-PCS	Procedure
027234Z	Dilation of Coronary Artery, Three Arteries with Drug-eluting Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
027235Z	Dilation of Coronary Artery, Three Arteries with Two Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
027236Z	Dilation of Coronary Artery, Three Arteries with Three Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
027237Z	Dilation of Coronary Artery, Three Arteries with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02723D6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02723DZ	Dilation of Coronary Artery, Three Arteries with Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02723EZ	Dilation of Coronary Artery, Three Arteries with Two Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02723F6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02723FZ	Dilation of Coronary Artery, Three Arteries with Three Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02723G6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02723GZ	Dilation of Coronary Artery, Three Arteries with Four or More Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02723T6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Radioactive Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02723TZ	Dilation of Coronary Artery, Three Arteries with Radioactive Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
027244Z	Dilation of Coronary Artery, Three Arteries with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027245Z	Dilation of Coronary Artery, Three Arteries with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027246Z	Dilation of Coronary Artery, Three Arteries with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027247Z	Dilation of Coronary Artery, Three Arteries with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02724D6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02724DZ	Dilation of Coronary Artery, Three Arteries with Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02724EZ	Dilation of Coronary Artery, Three Arteries with Two Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02724F6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02724FZ	Dilation of Coronary Artery, Three Arteries with Three Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02724G6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02724GZ	Dilation of Coronary Artery, Three Arteries with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02724T6	Dilation of Coronary Artery, Three Arteries, Bifurcation, with Radioactive Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02724TZ	Dilation of Coronary Artery, Three Arteries with Radioactive Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027304Z	Dilation of Coronary Artery, Four or More Arteries with Drug-eluting Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
027305Z	Dilation of Coronary Artery, Four or More Arteries with Two Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
027306Z	Dilation of Coronary Artery, Four or More Arteries with Three Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
027307Z	Dilation of Coronary Artery, Four or More Arteries with Four or More Drug-eluting Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02730D6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02730DZ	Dilation of Coronary Artery, Four or More Arteries with Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02730EZ	Dilation of Coronary Artery, Four or More Arteries with Two Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02730F6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Three Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02730FZ	Dilation of Coronary Artery, Four or More Arteries with Three Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02730G6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Four or More Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02730GZ	Dilation of Coronary Artery, Four or More Arteries with Four or More Intraluminal Devices, Open Approach	ICD-10-PCS	Procedure
02730T6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Radioactive Intraluminal Device, Open Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02730TZ	Dilation of Coronary Artery, Four or More Arteries with Radioactive Intraluminal Device, Open Approach	ICD-10-PCS	Procedure
02730Z6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, Open Approach	ICD-10-PCS	Procedure
02730ZZ	Dilation of Coronary Artery, Four or More Arteries, Open Approach	ICD-10-PCS	Procedure
027334Z	Dilation of Coronary Artery, Four or More Arteries with Drug-eluting Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
027335Z	Dilation of Coronary Artery, Four or More Arteries with Two Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
027336Z	Dilation of Coronary Artery, Four or More Arteries with Three Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
027337Z	Dilation of Coronary Artery, Four or More Arteries with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02733D6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02733DZ	Dilation of Coronary Artery, Four or More Arteries with Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02733EZ	Dilation of Coronary Artery, Four or More Arteries with Two Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02733F6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02733FZ	Dilation of Coronary Artery, Four or More Arteries with Three Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02733G6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02733GZ	Dilation of Coronary Artery, Four or More Arteries with Four or More Intraluminal Devices, Percutaneous Approach	ICD-10-PCS	Procedure
02733T6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Radioactive Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
02733TZ	Dilation of Coronary Artery, Four or More Arteries with Radioactive Intraluminal Device, Percutaneous Approach	ICD-10-PCS	Procedure
027344Z	Dilation of Coronary Artery, Four or More Arteries with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027345Z	Dilation of Coronary Artery, Four or More Arteries with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
027346Z	Dilation of Coronary Artery, Four or More Arteries with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
027347Z	Dilation of Coronary Artery, Four or More Arteries with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02734D6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02734DZ	Dilation of Coronary Artery, Four or More Arteries with Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02734EZ	Dilation of Coronary Artery, Four or More Arteries with Two Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02734F6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02734FZ	Dilation of Coronary Artery, Four or More Arteries with Three Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02734G6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02734GZ	Dilation of Coronary Artery, Four or More Arteries with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02734T6	Dilation of Coronary Artery, Four or More Arteries, Bifurcation, with Radioactive Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02734TZ	Dilation of Coronary Artery, Four or More Arteries with Radioactive Intraluminal Device, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02C00Z6	Extirpation of Matter from Coronary Artery, One Artery, Bifurcation, Open Approach	ICD-10-PCS	Procedure
02C00ZZ	Extirpation of Matter from Coronary Artery, One Artery, Open Approach	ICD-10-PCS	Procedure
02C03Z6	Extirpation of Matter from Coronary Artery, One Artery, Bifurcation, Percutaneous Approach	ICD-10-PCS	Procedure
02C03ZZ	Extirpation of Matter from Coronary Artery, One Artery, Percutaneous Approach	ICD-10-PCS	Procedure
02C04Z6	Extirpation of Matter from Coronary Artery, One Artery, Bifurcation, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02C04ZZ	Extirpation of Matter from Coronary Artery, One Artery, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02C10Z6	Extirpation of Matter from Coronary Artery, Two Arteries, Bifurcation, Open Approach	ICD-10-PCS	Procedure
02C10ZZ	Extirpation of Matter from Coronary Artery, Two Arteries, Open Approach	ICD-10-PCS	Procedure
02C13Z6	Extirpation of Matter from Coronary Artery, Two Arteries, Bifurcation, Percutaneous Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
02C13ZZ	Extirpation of Matter from Coronary Artery, Two Arteries, Percutaneous Approach	ICD-10-PCS	Procedure
02C14Z6	Extirpation of Matter from Coronary Artery, Two Arteries, Bifurcation, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02C14ZZ	Extirpation of Matter from Coronary Artery, Two Arteries, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02C20Z6	Extirpation of Matter from Coronary Artery, Three Arteries, Bifurcation, Open Approach	ICD-10-PCS	Procedure
02C20ZZ	Extirpation of Matter from Coronary Artery, Three Arteries, Open Approach	ICD-10-PCS	Procedure
02C23Z6	Extirpation of Matter from Coronary Artery, Three Arteries, Bifurcation, Percutaneous Approach	ICD-10-PCS	Procedure
02C23ZZ	Extirpation of Matter from Coronary Artery, Three Arteries, Percutaneous Approach	ICD-10-PCS	Procedure
02C24Z6	Extirpation of Matter from Coronary Artery, Three Arteries, Bifurcation, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02C24ZZ	Extirpation of Matter from Coronary Artery, Three Arteries, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02C30Z6	Extirpation of Matter from Coronary Artery, Four or More Arteries, Bifurcation, Open Approach	ICD-10-PCS	Procedure
02C30ZZ	Extirpation of Matter from Coronary Artery, Four or More Arteries, Open Approach	ICD-10-PCS	Procedure
02C33Z6	Extirpation of Matter from Coronary Artery, Four or More Arteries, Bifurcation, Percutaneous Approach	ICD-10-PCS	Procedure
02C33ZZ	Extirpation of Matter from Coronary Artery, Four or More Arteries, Percutaneous Approach	ICD-10-PCS	Procedure
02C34Z6	Extirpation of Matter from Coronary Artery, Four or More Arteries, Bifurcation, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
02C34ZZ	Extirpation of Matter from Coronary Artery, Four or More Arteries, Percutaneous Endoscopic Approach	ICD-10-PCS	Procedure
3E07017	Introduction of Other Thrombolytic into Coronary Artery, Open Approach	ICD-10-PCS	Procedure
3E070PZ	Introduction of Platelet Inhibitor into Coronary Artery, Open Approach	ICD-10-PCS	Procedure
3E07317	Introduction of Other Thrombolytic into Coronary Artery, Percutaneous Approach	ICD-10-PCS	Procedure
3E073PZ	Introduction of Platelet Inhibitor into Coronary Artery, Percutaneous Approach	ICD-10-PCS	Procedure
X2C0361	Extirpation of Matter from Coronary Artery, One Artery using Orbital Atherectomy Technology, Percutaneous Approach, New Technology Group 1	ICD-10-PCS	Procedure
X2C1361	Extirpation of Matter from Coronary Artery, Two Arteries using Orbital Atherectomy Technology, Percutaneous Approach, New Technology Group 1	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
X2C2361	Extirpation of Matter from Coronary Artery, Three Arteries using Orbital Atherectomy Technology, Percutaneous Approach, New Technology Group 1	ICD-10-PCS	Procedure
X2C3361	Extirpation of Matter from Coronary Artery, Four or More Arteries using Orbital Atherectomy Technology, Percutaneous Approach, New Technology Group 1	ICD-10-PCS	Procedure
G9641	Major amputation or open surgical bypass required within 48 hours of the index endovascular lower extremity revascularization procedure	HCPCS	Procedure
G9639	Major amputation or open surgical bypass not required within 48 hours of the index endovascular lower extremity revascularization procedure	HCPCS	Procedure
D3450	root amputation - per root	HCPCS	Procedure
33510	Coronary artery bypass, vein only; single coronary venous graft	CPT-4	Procedure
33511	Coronary artery bypass, vein only; 2 coronary venous grafts	CPT-4	Procedure
33512	Coronary artery bypass, vein only; 3 coronary venous grafts	CPT-4	Procedure
33513	Coronary artery bypass, vein only; 4 coronary venous grafts	CPT-4	Procedure
33514	Coronary artery bypass, vein only; 5 coronary venous grafts	CPT-4	Procedure
33516	Coronary artery bypass, vein only; 6 or more coronary venous grafts	CPT-4	Procedure
33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)	CPT-4	Procedure
33518	Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts (List separately in addition to code for primary procedure)	CPT-4	Procedure
33519	Coronary artery bypass, using venous graft(s) and arterial graft(s); 3 venous grafts (List separately in addition to code for primary procedure)	CPT-4	Procedure
33520	Coronary Artery Bypass, Nonautogenous Graft (eg, Synthetic Or Cadaver); Single Graft	CPT-4	Procedure
33521	Coronary artery bypass, using venous graft(s) and arterial graft(s); 4 venous grafts (List separately in addition to code for primary procedure)	CPT-4	Procedure
33522	Coronary artery bypass, using venous graft(s) and arterial graft(s); 5 venous grafts (List separately in addition to code for primary procedure)	CPT-4	Procedure
33523	Coronary artery bypass, using venous graft(s) and arterial graft(s); 6 or more venous grafts (List separately in addition to code for primary procedure)	CPT-4	Procedure
33525	Coronary Artery Bypass, Nonautogenous Graft (eg, Synthetic Or Cadaver); Two Coronary Grafts	CPT-4	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
33528	Coronary Artery Bypass, Nonautogenous Graft (eg, Synthetic Or Cadaver); Three Or More Coronary Grafts	CPT-4	Procedure
33530	Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)	CPT-4	Procedure
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	CPT-4	Procedure
33534	Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts	CPT-4	Procedure
33535	Coronary artery bypass, using arterial graft(s); 3 coronary arterial grafts	CPT-4	Procedure
33536	Coronary artery bypass, using arterial graft(s); 4 or more coronary arterial grafts	CPT-4	Procedure
33560	Myocardial Operation Combined With Coronary Bypass Procedure	CPT-4	Procedure
33570	CORONARY ANGIOPLASTY W/BYPASS	CPT-4	Procedure
33572	Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)	CPT-4	Procedure
33575	CORON ANGIOPLSTY W/BYPASS; COMBO W/VASCULARIZAT	CPT-4	Procedure
35454	Transluminal balloon angioplasty, open; iliac	CPT-4	Procedure
35456	Transluminal balloon angioplasty, open; femoral-popliteal	CPT-4	Procedure
35458	Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel	CPT-4	Procedure
35459	Transluminal balloon angioplasty, open; tibioperoneal trunk and branches	CPT-4	Procedure
35470	Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel	CPT-4	Procedure
35473	Transluminal balloon angioplasty, percutaneous; iliac	CPT-4	Procedure
35474	Transluminal balloon angioplasty, percutaneous; femoral-popliteal	CPT-4	Procedure
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	CPT-4	Procedure
35600	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)	CPT-4	Procedure
35879	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty	CPT-4	Procedure
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	CPT-4	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection	CPT-4	Procedure
37217	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation	CPT-4	Procedure
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	CPT-4	Procedure
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	CPT-4	Procedure
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	CPT-4	Procedure
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	CPT-4	Procedure
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	CPT-4	Procedure
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	CPT-4	Procedure
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	CPT-4	Procedure
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	CPT-4	Procedure
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	CPT-4	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	CPT-4	Procedure
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	CPT-4	Procedure
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	CPT-4	Procedure
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	CPT-4	Procedure
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	CPT-4	Procedure
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	CPT-4	Procedure
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	CPT-4	Procedure
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	CPT-4	Procedure
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	CPT-4	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
37237	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)	CPT-4	Procedure
61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	CPT-4	Procedure
61635	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	CPT-4	Procedure
75962	Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation	CPT-4	Procedure
75963	Percutaneous Transluminal Angioplasty, Any Method, Peripheral Artery; Complete Procedure	CPT-4	Procedure
75964	Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)	CPT-4	Procedure
75965	Percutaneous Transluminal Angioplasty, Any Method, Each Additional Peripheral Artery; Complete Procedure	CPT-4	Procedure
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	CPT-4	Procedure
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	CPT-4	Procedure
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	CPT-4	Procedure
92925	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	CPT-4	Procedure
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	CPT-4	Procedure
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	CPT-4	Procedure

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Code	Description	Code Type	Code Category
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	CPT-4	Procedure
92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	CPT-4	Procedure
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	CPT-4	Procedure
92938	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)	CPT-4	Procedure
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	CPT-4	Procedure
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	CPT-4	Procedure
92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)	CPT-4	Procedure
92973	Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)	CPT-4	Procedure
92974	Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)	CPT-4	Procedure
92977	Thrombolysis, coronary; by intravenous infusion	CPT-4	Procedure
92980	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	CPT-4	Procedure

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Code	Description	Code Type	Code Category
92981	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)	CPT-4	Procedure
92982	Percutaneous transluminal coronary balloon angioplasty; single vessel	CPT-4	Procedure
92984	Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	CPT-4	Procedure
92995	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel	CPT-4	Procedure
92996	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	CPT-4	Procedure
B2020ZZ	Plain Radiography of Single Coronary Artery Bypass Graft using High Osmolar Contrast	ICD-10-PCS	Procedure
B2021ZZ	Plain Radiography of Single Coronary Artery Bypass Graft using Low Osmolar Contrast	ICD-10-PCS	Procedure
B202YZZ	Plain Radiography of Single Coronary Artery Bypass Graft using Other Contrast	ICD-10-PCS	Procedure
B2030ZZ	Plain Radiography of Multiple Coronary Artery Bypass Grafts using High Osmolar Contrast	ICD-10-PCS	Procedure
B2031ZZ	Plain Radiography of Multiple Coronary Artery Bypass Grafts using Low Osmolar Contrast	ICD-10-PCS	Procedure
B203YZZ	Plain Radiography of Multiple Coronary Artery Bypass Grafts using Other Contrast	ICD-10-PCS	Procedure
B2070ZZ	Plain Radiography of Right Internal Mammary Bypass Graft using High Osmolar Contrast	ICD-10-PCS	Procedure
B2071ZZ	Plain Radiography of Right Internal Mammary Bypass Graft using Low Osmolar Contrast	ICD-10-PCS	Procedure
B207YZZ	Plain Radiography of Right Internal Mammary Bypass Graft using Other Contrast	ICD-10-PCS	Procedure
B2080ZZ	Plain Radiography of Left Internal Mammary Bypass Graft using High Osmolar Contrast	ICD-10-PCS	Procedure
B2081ZZ	Plain Radiography of Left Internal Mammary Bypass Graft using Low Osmolar Contrast	ICD-10-PCS	Procedure
B208YZZ	Plain Radiography of Left Internal Mammary Bypass Graft using Other Contrast	ICD-10-PCS	Procedure
B20F0ZZ	Plain Radiography of Other Bypass Graft using High Osmolar Contrast	ICD-10-PCS	Procedure
B20F1ZZ	Plain Radiography of Other Bypass Graft using Low Osmolar Contrast	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
B20FYZZ	Plain Radiography of Other Bypass Graft using Other Contrast	ICD-10-PCS	Procedure
B212010	Fluoroscopy of Single Coronary Artery Bypass Graft using High Osmolar Contrast, Laser Intraoperative	ICD-10-PCS	Procedure
B2120ZZ	Fluoroscopy of Single Coronary Artery Bypass Graft using High Osmolar Contrast	ICD-10-PCS	Procedure
B212110	Fluoroscopy of Single Coronary Artery Bypass Graft using Low Osmolar Contrast, Laser Intraoperative	ICD-10-PCS	Procedure
B2121ZZ	Fluoroscopy of Single Coronary Artery Bypass Graft using Low Osmolar Contrast	ICD-10-PCS	Procedure
B212Y10	Fluoroscopy of Single Coronary Artery Bypass Graft using Other Contrast, Laser Intraoperative	ICD-10-PCS	Procedure
B212YZZ	Fluoroscopy of Single Coronary Artery Bypass Graft using Other Contrast	ICD-10-PCS	Procedure
B213010	Fluoroscopy of Multiple Coronary Artery Bypass Grafts using High Osmolar Contrast, Laser Intraoperative	ICD-10-PCS	Procedure
B2130ZZ	Fluoroscopy of Multiple Coronary Artery Bypass Grafts using High Osmolar Contrast	ICD-10-PCS	Procedure
B213110	Fluoroscopy of Multiple Coronary Artery Bypass Grafts using Low Osmolar Contrast, Laser Intraoperative	ICD-10-PCS	Procedure
B2131ZZ	Fluoroscopy of Multiple Coronary Artery Bypass Grafts using Low Osmolar Contrast	ICD-10-PCS	Procedure
B213Y10	Fluoroscopy of Multiple Coronary Artery Bypass Grafts using Other Contrast, Laser Intraoperative	ICD-10-PCS	Procedure
B213YZZ	Fluoroscopy of Multiple Coronary Artery Bypass Grafts using Other Contrast	ICD-10-PCS	Procedure
B2170ZZ	Fluoroscopy of Right Internal Mammary Bypass Graft using High Osmolar Contrast	ICD-10-PCS	Procedure
B2171ZZ	Fluoroscopy of Right Internal Mammary Bypass Graft using Low Osmolar Contrast	ICD-10-PCS	Procedure
B217YZZ	Fluoroscopy of Right Internal Mammary Bypass Graft using Other Contrast	ICD-10-PCS	Procedure
B2180ZZ	Fluoroscopy of Left Internal Mammary Bypass Graft using High Osmolar Contrast	ICD-10-PCS	Procedure
B2181ZZ	Fluoroscopy of Left Internal Mammary Bypass Graft using Low Osmolar Contrast	ICD-10-PCS	Procedure
B218YZZ	Fluoroscopy of Left Internal Mammary Bypass Graft using Other Contrast	ICD-10-PCS	Procedure
B21F0ZZ	Fluoroscopy of Other Bypass Graft using High Osmolar Contrast	ICD-10-PCS	Procedure
B21F1ZZ	Fluoroscopy of Other Bypass Graft using Low Osmolar Contrast	ICD-10-PCS	Procedure
B21FYZZ	Fluoroscopy of Other Bypass Graft using Other Contrast	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	CPT-4	Procedure
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	CPT-4	Procedure
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	CPT-4	Procedure
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	CPT-4	Procedure
	Chronic Kidney Disease		
N14.0	Analgesic nephropathy	ICD-10-CM	Diagnosis
N26.1	Atrophy of kidney (terminal)	ICD-10-CM	Diagnosis
N15.0	Balkan nephropathy	ICD-10-CM	Diagnosis
N18.1	Chronic kidney disease, stage 1	ICD-10-CM	Diagnosis
N18.2	Chronic kidney disease, stage 2 (mild)	ICD-10-CM	Diagnosis
N18.3	Chronic kidney disease, stage 3 (moderate)	ICD-10-CM	Diagnosis
N18.30	Chronic kidney disease, stage 3 unspecified	ICD-10-CM	Diagnosis
N18.31	Chronic kidney disease, stage 3a	ICD-10-CM	Diagnosis
N18.32	Chronic kidney disease, stage 3b	ICD-10-CM	Diagnosis
N18.4	Chronic kidney disease, stage 4 (severe)	ICD-10-CM	Diagnosis
N18.5	Chronic kidney disease, stage 5	ICD-10-CM	Diagnosis
N18.9	Chronic kidney disease, unspecified	ICD-10-CM	Diagnosis
N03.A	Chronic nephritic syndrome with C3 glomerulonephritis	ICD-10-CM	Diagnosis
N03.6	Chronic nephritic syndrome with dense deposit disease	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
N03.7	Chronic nephritic syndrome with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N03.4	Chronic nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N03.2	Chronic nephritic syndrome with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N03.3	Chronic nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N03.5	Chronic nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N03.0	Chronic nephritic syndrome with minor glomerular abnormality	ICD-10-CM	Diagnosis
N03.8	Chronic nephritic syndrome with other morphologic changes	ICD-10-CM	Diagnosis
N03.9	Chronic nephritic syndrome with unspecified morphologic changes	ICD-10-CM	Diagnosis
Q61.02	Congenital multiple renal cysts	ICD-10-CM	Diagnosis
Q61.11	Cystic dilatation of collecting ducts	ICD-10-CM	Diagnosis
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy	ICD-10-CM	Diagnosis
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication	ICD-10-CM	Diagnosis
N25.9	Disorder resulting from impaired renal tubular function, unspecified	ICD-10-CM	Diagnosis
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E09.29	Drug or chemical induced diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
N18.6	End stage renal disease	ICD-10-CM	Diagnosis
M32.14	Glomerular disease in systemic lupus erythematosus	ICD-10-CM	Diagnosis
N08	Glomerular disorders in diseases classified elsewhere	ICD-10-CM	Diagnosis
M10.372	Gout due to renal impairment, left ankle and foot	ICD-10-CM	Diagnosis
M10.322	Gout due to renal impairment, left elbow	ICD-10-CM	Diagnosis
M10.342	Gout due to renal impairment, left hand	ICD-10-CM	Diagnosis
M10.352	Gout due to renal impairment, left hip	ICD-10-CM	Diagnosis
M10.362	Gout due to renal impairment, left knee	ICD-10-CM	Diagnosis
M10.312	Gout due to renal impairment, left shoulder	ICD-10-CM	Diagnosis
M10.332	Gout due to renal impairment, left wrist	ICD-10-CM	Diagnosis
M10.39	Gout due to renal impairment, multiple sites	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M10.371	Gout due to renal impairment, right ankle and foot	ICD-10-CM	Diagnosis
M10.321	Gout due to renal impairment, right elbow	ICD-10-CM	Diagnosis
M10.341	Gout due to renal impairment, right hand	ICD-10-CM	Diagnosis
M10.351	Gout due to renal impairment, right hip	ICD-10-CM	Diagnosis
M10.361	Gout due to renal impairment, right knee	ICD-10-CM	Diagnosis
M10.311	Gout due to renal impairment, right shoulder	ICD-10-CM	Diagnosis
M10.331	Gout due to renal impairment, right wrist	ICD-10-CM	Diagnosis
M10.379	Gout due to renal impairment, unspecified ankle and foot	ICD-10-CM	Diagnosis
M10.329	Gout due to renal impairment, unspecified elbow	ICD-10-CM	Diagnosis
M10.349	Gout due to renal impairment, unspecified hand	ICD-10-CM	Diagnosis
M10.359	Gout due to renal impairment, unspecified hip	ICD-10-CM	Diagnosis
M10.369	Gout due to renal impairment, unspecified knee	ICD-10-CM	Diagnosis
M10.319	Gout due to renal impairment, unspecified shoulder	ICD-10-CM	Diagnosis
M10.30	Gout due to renal impairment, unspecified site	ICD-10-CM	Diagnosis
M10.339	Gout due to renal impairment, unspecified wrist	ICD-10-CM	Diagnosis
M10.38	Gout due to renal impairment, vertebrae	ICD-10-CM	Diagnosis
K76.7	Hepatorenal syndrome	ICD-10-CM	Diagnosis
N07.A	Hereditary nephropathy, not elsewhere classified with C3 glomerulonephritis	ICD-10-CM	Diagnosis
N07.6	Hereditary nephropathy, not elsewhere classified with dense deposit disease	ICD-10-CM	Diagnosis
N07.7	Hereditary nephropathy, not elsewhere classified with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N07.4	Hereditary nephropathy, not elsewhere classified with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N07.2	Hereditary nephropathy, not elsewhere classified with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N07.3	Hereditary nephropathy, not elsewhere classified with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N07.5	Hereditary nephropathy, not elsewhere classified with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N07.1	Hereditary nephropathy, not elsewhere classified with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N07.0	Hereditary nephropathy, not elsewhere classified with minor glomerular abnormality	ICD-10-CM	Diagnosis
N07.8	Hereditary nephropathy, not elsewhere classified with other morphologic lesions	ICD-10-CM	Diagnosis
N07.9	Hereditary nephropathy, not elsewhere classified with unspecified morphologic lesions	ICD-10-CM	Diagnosis
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	ICD-10-CM	Diagnosis
I13.10	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	ICD-10-CM	Diagnosis
I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease	ICD-10-CM	Diagnosis
N06.A	Isolated proteinuria with C3 glomerulonephritis	ICD-10-CM	Diagnosis
N06.6	Isolated proteinuria with dense deposit disease	ICD-10-CM	Diagnosis
N06.7	Isolated proteinuria with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N06.4	Isolated proteinuria with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N06.2	Isolated proteinuria with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N06.3	Isolated proteinuria with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N06.5	Isolated proteinuria with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N06.1	Isolated proteinuria with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N06.0	Isolated proteinuria with minor glomerular abnormality	ICD-10-CM	Diagnosis
N06.8	Isolated proteinuria with other morphologic lesion	ICD-10-CM	Diagnosis
N06.9	Isolated proteinuria with unspecified morphologic lesion	ICD-10-CM	Diagnosis
Q61.5	Medullary cystic kidney	ICD-10-CM	Diagnosis
N25.1	Nephrogenic diabetes insipidus	ICD-10-CM	Diagnosis
N14.3	Nephropathy induced by heavy metals	ICD-10-CM	Diagnosis
N14.1	Nephropathy induced by other drugs, medicaments and biological substances	ICD-10-CM	Diagnosis
N14.2	Nephropathy induced by unspecified drug, medicament or biological substance	ICD-10-CM	Diagnosis
N04.A	Nephrotic syndrome with C3 glomerulonephritis	ICD-10-CM	Diagnosis
N04.6	Nephrotic syndrome with dense deposit disease	ICD-10-CM	Diagnosis
N04.7	Nephrotic syndrome with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N04.4	Nephrotic syndrome with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N04.2	Nephrotic syndrome with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
N04.3	Nephrotic syndrome with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N04.5	Nephrotic syndrome with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N04.1	Nephrotic syndrome with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N04.0	Nephrotic syndrome with minor glomerular abnormality	ICD-10-CM	Diagnosis
N04.8	Nephrotic syndrome with other morphologic changes	ICD-10-CM	Diagnosis
N04.9	Nephrotic syndrome with unspecified morphologic changes	ICD-10-CM	Diagnosis
Q61.8	Other cystic kidney diseases	ICD-10-CM	Diagnosis
N25.89	Other disorders resulting from impaired renal tubular function	ICD-10-CM	Diagnosis
Q61.19	Other polycystic kidney, infantile type	ICD-10-CM	Diagnosis
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E13.21	Other specified diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E13.29	Other specified diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
N15.8	Other specified renal tubulo-interstitial diseases	ICD-10-CM	Diagnosis
B52.0	Plasmodium malariae malaria with nephropathy	ICD-10-CM	Diagnosis
Q61.2	Polycystic kidney, adult type	ICD-10-CM	Diagnosis
Q61.3	Polycystic kidney, unspecified	ICD-10-CM	Diagnosis
N99.0	Postprocedural (acute) (chronic) kidney failure	ICD-10-CM	Diagnosis
N01.A	Rapidly progressive nephritic syndrome with C3 glomerulonephritis	ICD-10-CM	Diagnosis
N01.6	Rapidly progressive nephritic syndrome with dense deposit disease	ICD-10-CM	Diagnosis
N01.7	Rapidly progressive nephritic syndrome with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N01.4	Rapidly progressive nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N01.2	Rapidly progressive nephritic syndrome with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N01.3	Rapidly progressive nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N01.5	Rapidly progressive nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N01.1	Rapidly progressive nephritic syndrome with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N01.0	Rapidly progressive nephritic syndrome with minor glomerular abnormality	ICD-10-CM	Diagnosis
N01.8	Rapidly progressive nephritic syndrome with other morphologic changes	ICD-10-CM	Diagnosis
N01.9	Rapidly progressive nephritic syndrome with unspecified morphologic changes	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
N02.A	Recurrent and persistent hematuria with C3 glomerulonephritis	ICD-10-CM	Diagnosis
N02.6	Recurrent and persistent hematuria with dense deposit disease	ICD-10-CM	Diagnosis
N02.7	Recurrent and persistent hematuria with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N02.4	Recurrent and persistent hematuria with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N02.2	Recurrent and persistent hematuria with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N02.3	Recurrent and persistent hematuria with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N02.5	Recurrent and persistent hematuria with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N02.1	Recurrent and persistent hematuria with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N02.0	Recurrent and persistent hematuria with minor glomerular abnormality	ICD-10-CM	Diagnosis
N02.8	Recurrent and persistent hematuria with other morphologic changes	ICD-10-CM	Diagnosis
N02.9	Recurrent and persistent hematuria with unspecified morphologic changes	ICD-10-CM	Diagnosis
Q61.4	Renal dysplasia	ICD-10-CM	Diagnosis
N26.9	Renal sclerosis, unspecified	ICD-10-CM	Diagnosis
N15.9	Renal tubulo-interstitial disease, unspecified	ICD-10-CM	Diagnosis
N16	Renal tubulo-interstitial disorders in diseases classified elsewhere	ICD-10-CM	Diagnosis
M35.0A	Sjogren syndrome with glomerular disease	ICD-10-CM	Diagnosis
M35.04	Sjogren syndrome with tubulo-interstitial nephropathy	ICD-10-CM	Diagnosis
A52.75	Syphilis of kidney and ureter	ICD-10-CM	Diagnosis
N14.4	Toxic nephropathy, not elsewhere classified	ICD-10-CM	Diagnosis
A18.11	Tuberculosis of kidney and ureter	ICD-10-CM	Diagnosis
M32.15	Tubulo-interstitial nephropathy in systemic lupus erythematosus	ICD-10-CM	Diagnosis
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E10.21	Type 1 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E11.21	Type 2 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
N05.A	Unspecified nephritic syndrome with C3 glomerulonephritis	ICD-10-CM	Diagnosis
N05.6	Unspecified nephritic syndrome with dense deposit disease	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
N05.7	Unspecified nephritic syndrome with diffuse crescentic glomerulonephritis	ICD-10-CM	Diagnosis
N05.4	Unspecified nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N05.2	Unspecified nephritic syndrome with diffuse membranous glomerulonephritis	ICD-10-CM	Diagnosis
N05.3	Unspecified nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	ICD-10-CM	Diagnosis
N05.5	Unspecified nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	ICD-10-CM	Diagnosis
N05.1	Unspecified nephritic syndrome with focal and segmental glomerular lesions	ICD-10-CM	Diagnosis
N05.0	Unspecified nephritic syndrome with minor glomerular abnormality	ICD-10-CM	Diagnosis
N05.8	Unspecified nephritic syndrome with other morphologic changes	ICD-10-CM	Diagnosis
N05.9	Unspecified nephritic syndrome with unspecified morphologic changes	ICD-10-CM	Diagnosis
442.1	Aneurysm of renal artery	ICD-9-CM	Diagnosis
440.1	Atherosclerosis of renal artery	ICD-9-CM	Diagnosis
223.0	Benign neoplasm of kidney, except pelvis	ICD-9-CM	Diagnosis
582.89	Other chronic glomerulonephritis with specified pathological lesion in kidney	ICD-9-CM	Diagnosis
582.81	Chronic glomerulonephritis with other specified pathological lesion in kidney in diseases classified elsewhere	ICD-9-CM	Diagnosis
582.1	Chronic glomerulonephritis with lesion of membranous glomerulonephritis	ICD-9-CM	Diagnosis
582.2	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis	ICD-9-CM	Diagnosis
582.0	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis	ICD-9-CM	Diagnosis
582.4	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis	ICD-9-CM	Diagnosis
582.9	Chronic glomerulonephritis with unspecified pathological lesion in kidney	ICD-9-CM	Diagnosis
585.1	Chronic kidney disease, Stage I	ICD-9-CM	Diagnosis
585.2	Chronic kidney disease, Stage II (mild)	ICD-9-CM	Diagnosis
585.3	Chronic kidney disease, Stage III (moderate)	ICD-9-CM	Diagnosis
585.4	Chronic kidney disease, Stage IV (severe)	ICD-9-CM	Diagnosis
585.5	Chronic kidney disease, Stage V	ICD-9-CM	Diagnosis
585.9	Chronic kidney disease, unspecified	ICD-9-CM	Diagnosis
753.16	Congenital medullary cystic kidney	ICD-9-CM	Diagnosis
753.17	Congenital medullary sponge kidney	ICD-9-CM	Diagnosis
753.21	Congenital obstruction of ureteropelvic junction	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
753.22	Congenital obstruction of ureterovesical junction	ICD-9-CM	Diagnosis
753.13	Congenital polycystic kidney, autosomal dominant	ICD-9-CM	Diagnosis
753.14	Congenital polycystic kidney, autosomal recessive	ICD-9-CM	Diagnosis
753.12	Congenital polycystic kidney, unspecified type	ICD-9-CM	Diagnosis
753.15	Congenital renal dysplasia	ICD-9-CM	Diagnosis
753.23	Congenital ureterocele	ICD-9-CM	Diagnosis
250.43	Diabetes with renal manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.41	Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.40	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.42	Diabetes with renal manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
585.6	End stage renal disease	ICD-9-CM	Diagnosis
274.10	Gouty nephropathy, unspecified	ICD-9-CM	Diagnosis
283.11	Hemolytic-uremic syndrome	ICD-9-CM	Diagnosis
572.4	Hepatorenal syndrome	ICD-9-CM	Diagnosis
403.01	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
403.11	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
403.91	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.02	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.12	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
404.92	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease	ICD-9-CM	Diagnosis
591	Hydronephrosis	ICD-9-CM	Diagnosis
189.0	Malignant neoplasm of kidney, except pelvis	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
189.9	Malignant neoplasm of urinary organ, site unspecified	ICD-9-CM	Diagnosis
236.91	Neoplasm of uncertain behavior of kidney and ureter	ICD-9-CM	Diagnosis
583.6	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal cortical necrosis	ICD-9-CM	Diagnosis
583.81	Nephritis and nephropathy, not specified as acute or chronic, with other specified pathological lesion in kidney, in diseases classified elsewhere	ICD-9-CM	Diagnosis
583.7	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal medullary necrosis	ICD-9-CM	Diagnosis
583.2	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranoproliferative glomerulonephritis	ICD-9-CM	Diagnosis
583.4	Nephritis and nephropathy, not specified as acute or chronic, with lesion of rapidly progressive glomerulonephritis	ICD-9-CM	Diagnosis
583.89	Other nephritis and nephropathy, not specified as acute or chronic, with specified pathological lesion in kidney	ICD-9-CM	Diagnosis
583.0	Nephritis and nephropathy, not specified as acute or chronic, with lesion of proliferative glomerulonephritis	ICD-9-CM	Diagnosis
583.9	Nephritis and nephropathy, not specified as acute or chronic, with unspecified pathological lesion in kidney	ICD-9-CM	Diagnosis
583.1	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranous glomerulonephritis	ICD-9-CM	Diagnosis
588.1	Nephrogenic diabetes insipidus	ICD-9-CM	Diagnosis
581.3	Nephrotic syndrome with lesion of minimal change glomerulonephritis	ICD-9-CM	Diagnosis
581.2	Nephrotic syndrome with lesion of membranoproliferative glomerulonephritis	ICD-9-CM	Diagnosis
581.81	Nephrotic syndrome with other specified pathological lesion in kidney in diseases classified elsewhere	ICD-9-CM	Diagnosis
581.1	Nephrotic syndrome with lesion of membranous glomerulonephritis	ICD-9-CM	Diagnosis
581.0	Nephrotic syndrome with lesion of proliferative glomerulonephritis	ICD-9-CM	Diagnosis
581.9	Nephrotic syndrome with unspecified pathological lesion in kidney	ICD-9-CM	Diagnosis
794.4	Nonspecific abnormal results of kidney function study	ICD-9-CM	Diagnosis
580.89	Other acute glomerulonephritis with other specified pathological lesion in kidney	ICD-9-CM	Diagnosis
581.89	Other nephrotic syndrome with specified pathological lesion in kidney	ICD-9-CM	Diagnosis
588.89	Other specified disorders resulting from impaired renal function	ICD-9-CM	Diagnosis
753.29	Other obstructive defect of renal pelvis and ureter	ICD-9-CM	Diagnosis
753.19	Other specified congenital cystic kidney disease	ICD-9-CM	Diagnosis
271.4	Renal glycosuria	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
588.0	Renal osteodystrophy	ICD-9-CM	Diagnosis
249.40	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.41	Secondary diabetes mellitus with renal manifestations, uncontrolled	ICD-9-CM	Diagnosis
588.81	Secondary hyperparathyroidism (of renal origin)	ICD-9-CM	Diagnosis
095.4	Syphilis of kidney	ICD-9-CM	Diagnosis
016.02	Tuberculosis of kidney, bacteriological or histological examination unknown (at present)	ICD-9-CM	Diagnosis
016.01	Tuberculosis of kidney, bacteriological or histological examination not done	ICD-9-CM	Diagnosis
016.04	Tuberculosis of kidney, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture	ICD-9-CM	Diagnosis
016.05	Tuberculosis of kidney, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically	ICD-9-CM	Diagnosis
016.06	Tuberculosis of kidney, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods [inoculation of animals]	ICD-9-CM	Diagnosis
016.03	Tuberculosis of kidney, tubercle bacilli found (in sputum) by microscopy	ICD-9-CM	Diagnosis
016.00	Tuberculosis of kidney, confirmation unspecified	ICD-9-CM	Diagnosis
588.9	Unspecified disorder resulting from impaired renal function	ICD-9-CM	Diagnosis
753.20	Unspecified obstructive defect of renal pelvis and ureter	ICD-9-CM	Diagnosis
586	Unspecified renal failure	ICD-9-CM	Diagnosis
587	Unspecified renal sclerosis	ICD-9-CM	Diagnosis
	Chronic Obstructive Pulmonary Disorder		
J47.1	Bronchiectasis with (acute) exacerbation	ICD-10-CM	Diagnosis
J47.0	Bronchiectasis with acute lower respiratory infection	ICD-10-CM	Diagnosis
J47.9	Bronchiectasis, uncomplicated	ICD-10-CM	Diagnosis
J40	Bronchitis, not specified as acute or chronic	ICD-10-CM	Diagnosis
J43.2	Centrilobular emphysema	ICD-10-CM	Diagnosis
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation	ICD-10-CM	Diagnosis
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection	ICD-10-CM	Diagnosis
J44.9	Chronic obstructive pulmonary disease, unspecified	ICD-10-CM	Diagnosis
J98.3	Compensatory emphysema	ICD-10-CM	Diagnosis
J43.9	Emphysema, unspecified	ICD-10-CM	Diagnosis
J98.2	Interstitial emphysema	ICD-10-CM	Diagnosis
J41.8	Mixed simple and mucopurulent chronic bronchitis	ICD-10-CM	Diagnosis
J41.1	Mucopurulent chronic bronchitis	ICD-10-CM	Diagnosis
J43.1	Panlobular emphysema	ICD-10-CM	Diagnosis
J41.0	Simple chronic bronchitis	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
J43.0	Unilateral pulmonary emphysema [MacLeod's syndrome]	ICD-10-CM	Diagnosis
J42	Unspecified chronic bronchitis	ICD-10-CM	Diagnosis
494.1	Bronchiectasis with acute exacerbation	ICD-9-CM	Diagnosis
494.0	Bronchiectasis without acute exacerbation	ICD-9-CM	Diagnosis
490	Bronchitis, not specified as acute or chronic	ICD-9-CM	Diagnosis
496	Chronic airway obstruction, not elsewhere classified	ICD-9-CM	Diagnosis
492.0	Emphysematous bleb	ICD-9-CM	Diagnosis
491.1	Mucopurulent chronic bronchitis	ICD-9-CM	Diagnosis
491.22	Obstructive chronic bronchitis with acute bronchitis	ICD-9-CM	Diagnosis
491.21	Obstructive chronic bronchitis, with (acute) exacerbation	ICD-9-CM	Diagnosis
491.20	Obstructive chronic bronchitis, without exacerbation	ICD-9-CM	Diagnosis
491.8	Other chronic bronchitis	ICD-9-CM	Diagnosis
492.8	Other emphysema	ICD-9-CM	Diagnosis
491.0	Simple chronic bronchitis	ICD-9-CM	Diagnosis
491.9	Unspecified chronic bronchitis	ICD-9-CM	Diagnosis
	Depressive Disorder		
F32.A	Depression, unspecified	ICD-10-CM	Diagnosis
F34.1	Dysthymic disorder	ICD-10-CM	Diagnosis
F33.2	Major depressive disorder, recurrent severe without psychotic features	ICD-10-CM	Diagnosis
F33.42	Major depressive disorder, recurrent, in full remission	ICD-10-CM	Diagnosis
F33.41	Major depressive disorder, recurrent, in partial remission	ICD-10-CM	Diagnosis
F33.40	Major depressive disorder, recurrent, in remission, unspecified	ICD-10-CM	Diagnosis
F33.0	Major depressive disorder, recurrent, mild	ICD-10-CM	Diagnosis
F33.1	Major depressive disorder, recurrent, moderate	ICD-10-CM	Diagnosis
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	ICD-10-CM	Diagnosis
F33.9	Major depressive disorder, recurrent, unspecified	ICD-10-CM	Diagnosis
F32.5	Major depressive disorder, single episode, in full remission	ICD-10-CM	Diagnosis
F32.4	Major depressive disorder, single episode, in partial remission	ICD-10-CM	Diagnosis
F32.0	Major depressive disorder, single episode, mild	ICD-10-CM	Diagnosis
F32.1	Major depressive disorder, single episode, moderate	ICD-10-CM	Diagnosis
F32.3	Major depressive disorder, single episode, severe with psychotic features	ICD-10-CM	Diagnosis
F32.2	Major depressive disorder, single episode, severe without psychotic features	ICD-10-CM	Diagnosis
F32.9	Major depressive disorder, single episode, unspecified	ICD-10-CM	Diagnosis
F33.8	Other recurrent depressive disorders	ICD-10-CM	Diagnosis
F32.89	Other specified depressive episodes	ICD-10-CM	Diagnosis
311	Depressive disorder, not elsewhere classified	ICD-9-CM	Diagnosis
300.4	Dysthymic disorder	ICD-9-CM	Diagnosis
296.24	Major depressive disorder, single episode, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
296.23	Major depressive disorder, single episode, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.35	Major depressive disorder, recurrent episode, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.34	Major depressive disorder, recurrent episode, severe, specified as with psychotic behavior	ICD-9-CM	Diagnosis
296.33	Major depressive disorder, recurrent episode, severe, without mention of psychotic behavior	ICD-9-CM	Diagnosis
296.25	Major depressive disorder, single episode, in partial or unspecified remission	ICD-9-CM	Diagnosis
296.31	Major depressive disorder, recurrent episode, mild	ICD-9-CM	Diagnosis
296.21	Major depressive disorder, single episode, mild	ICD-9-CM	Diagnosis
296.20	Major depressive disorder, single episode, unspecified	ICD-9-CM	Diagnosis
296.36	Major depressive disorder, recurrent episode, in full remission	ICD-9-CM	Diagnosis
296.32	Major depressive disorder, recurrent episode, moderate	ICD-9-CM	Diagnosis
296.30	Major depressive disorder, recurrent episode, unspecified	ICD-9-CM	Diagnosis
296.26	Major depressive disorder, single episode in full remission	ICD-9-CM	Diagnosis
296.22	Major depressive disorder, single episode, moderate	ICD-9-CM	Diagnosis
	Diabetes		
E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy	ICD-10-CM	Diagnosis
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract	ICD-10-CM	Diagnosis
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E08.620	Diabetes mellitus due to underlying condition with diabetic dermatitis	ICD-10-CM	Diagnosis
E08.37X3	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, bilateral	ICD-10-CM	Diagnosis
E08.37X2	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, left eye	ICD-10-CM	Diagnosis
E08.37X1	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, right eye	ICD-10-CM	Diagnosis
E08.37X9	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy	ICD-10-CM	Diagnosis
E08.610	Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E08.621	Diabetes mellitus due to underlying condition with foot ulcer	ICD-10-CM	Diagnosis
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia	ICD-10-CM	Diagnosis
E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma	ICD-10-CM	Diagnosis
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	ICD-10-CM	Diagnosis
E08.641	Diabetes mellitus due to underlying condition with hypoglycemia with coma	ICD-10-CM	Diagnosis
E08.649	Diabetes mellitus due to underlying condition with hypoglycemia without coma	ICD-10-CM	Diagnosis
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma	ICD-10-CM	Diagnosis
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma	ICD-10-CM	Diagnosis
E08.321	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E08.3219	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.329	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.3293	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
E08.3292	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E08.3291	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E08.3299	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.331	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E08.3319	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.339	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.3393	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3392	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E08.3391	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E08.3399	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.59	Diabetes mellitus due to underlying condition with other circulatory complications	ICD-10-CM	Diagnosis
E08.618	Diabetes mellitus due to underlying condition with other diabetic arthropathy	ICD-10-CM	Diagnosis
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication	ICD-10-CM	Diagnosis
E08.39	Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E08.638	Diabetes mellitus due to underlying condition with other oral complications	ICD-10-CM	Diagnosis
E08.628	Diabetes mellitus due to underlying condition with other skin complications	ICD-10-CM	Diagnosis
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer	ICD-10-CM	Diagnosis
E08.69	Diabetes mellitus due to underlying condition with other specified complication	ICD-10-CM	Diagnosis
E08.630	Diabetes mellitus due to underlying condition with periodontal disease	ICD-10-CM	Diagnosis
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E08.3549	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E08.351	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E08.3519	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E08.3529	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E08.3539	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E08.359	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E08.3599	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.341	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E08.3419	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.349	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.3493	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E08.3492	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E08.3491	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E08.3499	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E08.3559	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis
E08.8	Diabetes mellitus due to underlying condition with unspecified complications	ICD-10-CM	Diagnosis
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E08.9	Diabetes mellitus due to underlying condition without complications	ICD-10-CM	Diagnosis
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E09.620	Drug or chemical induced diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E09.37X3	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	ICD-10-CM	Diagnosis
E09.37X2	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, left eye	ICD-10-CM	Diagnosis
E09.37X1	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	ICD-10-CM	Diagnosis
E09.37X9	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E09.610	Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E09.52	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma	ICD-10-CM	Diagnosis
E09.00	Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	ICD-10-CM	Diagnosis
E09.641	Drug or chemical induced diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E09.649	Drug or chemical induced diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E09.11	Drug or chemical induced diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E09.321	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.3213	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3212	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E09.3211	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E09.3219	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.329	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E09.3293	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3292	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E09.3291	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E09.3299	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.331	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.3313	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3312	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E09.3311	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E09.3319	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.339	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E09.3393	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3392	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E09.3391	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E09.3399	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.44	Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy	ICD-10-CM	Diagnosis
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E09.49	Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication	ICD-10-CM	Diagnosis
E09.59	Drug or chemical induced diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis
E09.618	Drug or chemical induced diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E09.29	Drug or chemical induced diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E09.39	Drug or chemical induced diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E09.638	Drug or chemical induced diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E09.628	Drug or chemical induced diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E09.69	Drug or chemical induced diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E09.630	Drug or chemical induced diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis
E09.3543	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E09.3542	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E09.3541	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E09.3549	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E09.351	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.3513	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3512	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E09.3511	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E09.3519	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.3523	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis
E09.3522	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E09.3521	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E09.3529	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E09.3533	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis
E09.3532	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E09.3531	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E09.3539	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E09.359	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E09.3593	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3592	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E09.3591	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E09.3599	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.341	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.3413	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3412	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E09.3411	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E09.3419	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.349	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E09.3493	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E09.3492	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E09.3491	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E09.3499	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E09.3553	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E09.3552	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E09.3551	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E09.3559	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E09.311	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E09.319	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E09.9	Drug or chemical induced diabetes mellitus without complications	ICD-10-CM	Diagnosis
E13.44	Other specified diabetes mellitus with diabetic amyotrophy	ICD-10-CM	Diagnosis
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E13.36	Other specified diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E13.620	Other specified diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E13.21	Other specified diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E13.610	Other specified diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E13.40	Other specified diabetes mellitus with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E13.52	Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E13.51	Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E13.621	Other specified diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E13.65	Other specified diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E13.01	Other specified diabetes mellitus with hyperosmolarity with coma	ICD-10-CM	Diagnosis
E13.00	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	ICD-10-CM	Diagnosis
E13.641	Other specified diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E13.649	Other specified diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E13.11	Other specified diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E13.10	Other specified diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E13.321	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E13.3213	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3212	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E13.3211	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E13.3219	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.329	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E13.3293	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3292	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E13.3291	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E13.3299	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.331	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E13.3313	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3312	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E13.3311	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E13.3319	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.339	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E13.3393	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3392	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E13.3391	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E13.3399	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.59	Other specified diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis
E13.618	Other specified diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E13.29	Other specified diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E13.49	Other specified diabetes mellitus with other diabetic neurological complication	ICD-10-CM	Diagnosis
E13.39	Other specified diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E13.638	Other specified diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E13.628	Other specified diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E13.622	Other specified diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E13.69	Other specified diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E13.630	Other specified diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis
E13.3543	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E13.3542	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis
E13.3541	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E13.3549	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E13.351	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E13.3513	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3512	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E13.3511	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E13.3519	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.3523	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
E13.3522	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E13.3521	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E13.3529	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E13.3533	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis
E13.3532	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E13.3531	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E13.3539	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E13.359	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E13.3593	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3592	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E13.3591	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E13.3599	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.341	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E13.3413	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3412	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E13.3411	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E13.3419	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.349	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E13.3493	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E13.3492	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E13.3491	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E13.3499	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E13.3553	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E13.3552	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E13.3551	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E13.3559	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis
E13.8	Other specified diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E13.311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E13.319	Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E13.9	Other specified diabetes mellitus without complications	ICD-10-CM	Diagnosis
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy	ICD-10-CM	Diagnosis
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E10.36	Type 1 diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E10.620	Type 1 diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E10.37X3	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	ICD-10-CM	Diagnosis
E10.37X2	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye	ICD-10-CM	Diagnosis
E10.37X1	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	ICD-10-CM	Diagnosis
E10.37X9	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E10.21	Type 1 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy	ICD-10-CM	Diagnosis
E10.621	Type 1 diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E10.65	Type 1 diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E10.641	Type 1 diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E10.321	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3219	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.329	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.3293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3292	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.3291	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3299	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3319	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.339	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.3393	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E10.3392	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.3391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3399	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.59	Type 1 diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis
E10.618	Type 1 diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication	ICD-10-CM	Diagnosis
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E10.638	Type 1 diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E10.628	Type 1 diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E10.622	Type 1 diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E10.69	Type 1 diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E10.630	Type 1 diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E10.3549	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E10.351	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3519	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E10.3529	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis
E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E10.3539	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E10.359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3599	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.341	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E10.3419	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.349	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.3493	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E10.3499	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E10.3559	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis
E10.8	Type 1 diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E10.9	Type 1 diabetes mellitus without complications	ICD-10-CM	Diagnosis
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy	ICD-10-CM	Diagnosis
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy	ICD-10-CM	Diagnosis
E11.36	Type 2 diabetes mellitus with diabetic cataract	ICD-10-CM	Diagnosis
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	ICD-10-CM	Diagnosis
E11.620	Type 2 diabetes mellitus with diabetic dermatitis	ICD-10-CM	Diagnosis
E11.37X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral	ICD-10-CM	Diagnosis
E11.37X2	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye	ICD-10-CM	Diagnosis
E11.37X1	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye	ICD-10-CM	Diagnosis
E11.37X9	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye	ICD-10-CM	Diagnosis
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy	ICD-10-CM	Diagnosis
E11.21	Type 2 diabetes mellitus with diabetic nephropathy	ICD-10-CM	Diagnosis
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy	ICD-10-CM	Diagnosis
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified	ICD-10-CM	Diagnosis
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene	ICD-10-CM	Diagnosis
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	ICD-10-CM	Diagnosis
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E11.621	Type 2 diabetes mellitus with foot ulcer	ICD-10-CM	Diagnosis
E11.65	Type 2 diabetes mellitus with hyperglycemia	ICD-10-CM	Diagnosis
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma	ICD-10-CM	Diagnosis
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	ICD-10-CM	Diagnosis
E11.641	Type 2 diabetes mellitus with hypoglycemia with coma	ICD-10-CM	Diagnosis
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma	ICD-10-CM	Diagnosis
E11.11	Type 2 diabetes mellitus with ketoacidosis with coma	ICD-10-CM	Diagnosis
E11.10	Type 2 diabetes mellitus with ketoacidosis without coma	ICD-10-CM	Diagnosis
E11.321	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3219	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.3293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E11.3291	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3299	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3319	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.3393	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E11.3392	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3399	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.59	Type 2 diabetes mellitus with other circulatory complications	ICD-10-CM	Diagnosis
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy	ICD-10-CM	Diagnosis
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication	ICD-10-CM	Diagnosis
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication	ICD-10-CM	Diagnosis
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication	ICD-10-CM	Diagnosis
E11.638	Type 2 diabetes mellitus with other oral complications	ICD-10-CM	Diagnosis
E11.628	Type 2 diabetes mellitus with other skin complications	ICD-10-CM	Diagnosis
E11.622	Type 2 diabetes mellitus with other skin ulcer	ICD-10-CM	Diagnosis
E11.69	Type 2 diabetes mellitus with other specified complication	ICD-10-CM	Diagnosis
E11.630	Type 2 diabetes mellitus with periodontal disease	ICD-10-CM	Diagnosis
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	ICD-10-CM	Diagnosis
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	ICD-10-CM	Diagnosis
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	ICD-10-CM	Diagnosis
E11.3549	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	ICD-10-CM	Diagnosis
E11.351	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3519	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	ICD-10-CM	Diagnosis
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	ICD-10-CM	Diagnosis
E11.3529	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	ICD-10-CM	Diagnosis
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	ICD-10-CM	Diagnosis
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	ICD-10-CM	Diagnosis
E11.3539	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	ICD-10-CM	Diagnosis
E11.359	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3599	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	ICD-10-CM	Diagnosis
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	ICD-10-CM	Diagnosis
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	ICD-10-CM	Diagnosis
E11.3419	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.3493	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
E11.3492	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	ICD-10-CM	Diagnosis
E11.3491	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	ICD-10-CM	Diagnosis
E11.3499	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	ICD-10-CM	Diagnosis
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	ICD-10-CM	Diagnosis
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	ICD-10-CM	Diagnosis
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	ICD-10-CM	Diagnosis
E11.3559	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	ICD-10-CM	Diagnosis
E11.8	Type 2 diabetes mellitus with unspecified complications	ICD-10-CM	Diagnosis
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema	ICD-10-CM	Diagnosis
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema	ICD-10-CM	Diagnosis
E11.9	Type 2 diabetes mellitus without complications	ICD-10-CM	Diagnosis
362.01	Background diabetic retinopathy	ICD-9-CM	Diagnosis
250.23	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.21	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.20	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.22	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.11	Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.10	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.63	Diabetes with neurological manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.61	Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.60	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.62	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.01	Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.03	Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.02	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.53	Diabetes with ophthalmic manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.51	Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.50	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.52	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.31	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.30	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.83	Diabetes with other specified manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.81	Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.80	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.82	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.73	Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.71	Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.70	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.72	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.43	Diabetes with renal manifestations, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.41	Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis
250.40	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.42	Diabetes with renal manifestations, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.91	Diabetes with unspecified complication, type I [juvenile type], not stated as uncontrolled	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
250.90	Diabetes with unspecified complication, type II or unspecified type, not stated as uncontrolled	ICD-9-CM	Diagnosis
250.93	Diabetes with unspecified complication, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.92	Diabetes with unspecified complication, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.13	Diabetes with ketoacidosis, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.12	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
250.33	Diabetes with other coma, type I [juvenile type], uncontrolled	ICD-9-CM	Diagnosis
250.32	Diabetes with other coma, type II or unspecified type, uncontrolled	ICD-9-CM	Diagnosis
366.41	Diabetic cataract	ICD-9-CM	Diagnosis
362.04	Mild nonproliferative diabetic retinopathy	ICD-9-CM	Diagnosis
362.05	Moderate nonproliferative diabetic retinopathy	ICD-9-CM	Diagnosis
362.03	Nonproliferative diabetic retinopathy NOS	ICD-9-CM	Diagnosis
357.2	Polyneuropathy in diabetes	ICD-9-CM	Diagnosis
362.02	Proliferative diabetic retinopathy	ICD-9-CM	Diagnosis
249.60	Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.50	Secondary diabetes mellitus with ophthalmic manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.20	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.10	Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.61	Secondary diabetes mellitus with neurological manifestations, uncontrolled	ICD-9-CM	Diagnosis
249.00	Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.01	Secondary diabetes mellitus without mention of complication, uncontrolled	ICD-9-CM	Diagnosis
249.51	Secondary diabetes mellitus with ophthalmic manifestations, uncontrolled	ICD-9-CM	Diagnosis
249.80	Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.81	Secondary diabetes mellitus with other specified manifestations, uncontrolled	ICD-9-CM	Diagnosis
249.30	Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.70	Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.71	Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
249.40	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.41	Secondary diabetes mellitus with renal manifestations, uncontrolled	ICD-9-CM	Diagnosis
249.90	Secondary diabetes mellitus with unspecified complication, not stated as uncontrolled, or unspecified	ICD-9-CM	Diagnosis
249.91	Secondary diabetes mellitus with unspecified complication, uncontrolled	ICD-9-CM	Diagnosis
249.21	Secondary diabetes mellitus with hyperosmolarity, uncontrolled	ICD-9-CM	Diagnosis
249.11	Secondary diabetes mellitus with ketoacidosis, uncontrolled	ICD-9-CM	Diagnosis
249.31	Secondary diabetes mellitus with other coma, uncontrolled	ICD-9-CM	Diagnosis
362.06	Severe nonproliferative diabetic retinopathy	ICD-9-CM	Diagnosis
	Post-Traumatic Stress Disorder		
F43.11	Post-traumatic stress disorder, acute	ICD-10-CM	Diagnosis
F43.12	Post-traumatic stress disorder, chronic	ICD-10-CM	Diagnosis
F43.10	Post-traumatic stress disorder, unspecified	ICD-10-CM	Diagnosis
309.81	Posttraumatic stress disorder	ICD-9-CM	Diagnosis
	Schizophrenia and Schizoaffective Disorder		
F23	Brief psychotic disorder	ICD-10-CM	Diagnosis
F20.2	Catatonic schizophrenia	ICD-10-CM	Diagnosis
F22	Delusional disorders	ICD-10-CM	Diagnosis
F20.1	Disorganized schizophrenia	ICD-10-CM	Diagnosis
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	ICD-10-CM	Diagnosis
F32.3	Major depressive disorder, single episode, severe with psychotic features	ICD-10-CM	Diagnosis
F44.89	Other dissociative and conversion disorders	ICD-10-CM	Diagnosis
F28	Other psychotic disorder not due to a substance or known physiological condition	ICD-10-CM	Diagnosis
F25.8	Other schizoaffective disorders	ICD-10-CM	Diagnosis
F20.89	Other schizophrenia	ICD-10-CM	Diagnosis
F20.0	Paranoid schizophrenia	ICD-10-CM	Diagnosis
F06.2	Psychotic disorder with delusions due to known physiological condition	ICD-10-CM	Diagnosis
F06.0	Psychotic disorder with hallucinations due to known physiological condition	ICD-10-CM	Diagnosis
F20.5	Residual schizophrenia	ICD-10-CM	Diagnosis
F25.0	Schizoaffective disorder, bipolar type	ICD-10-CM	Diagnosis
F25.1	Schizoaffective disorder, depressive type	ICD-10-CM	Diagnosis
F25.9	Schizoaffective disorder, unspecified	ICD-10-CM	Diagnosis
F20.9	Schizophrenia, unspecified	ICD-10-CM	Diagnosis
F20.81	Schizophreniform disorder	ICD-10-CM	Diagnosis
F21	Schizotypal disorder	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F24	Shared psychotic disorder	ICD-10-CM	Diagnosis
F20.3	Undifferentiated schizophrenia	ICD-10-CM	Diagnosis
F29	Unspecified psychosis not due to a substance or known physiological condition	ICD-10-CM	Diagnosis
298.3	Acute paranoid reaction	ICD-9-CM	Diagnosis
295.24	Catatonic schizophrenia, chronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.23	Catatonic schizophrenia, subchronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.22	Catatonic schizophrenia, chronic condition	ICD-9-CM	Diagnosis
295.25	Catatonic schizophrenia, in remission	ICD-9-CM	Diagnosis
295.21	Catatonic schizophrenia, subchronic condition	ICD-9-CM	Diagnosis
295.20	Catatonic schizophrenia, unspecified condition	ICD-9-CM	Diagnosis
297.1	Delusional disorder	ICD-9-CM	Diagnosis
298.0	Depressive type psychosis	ICD-9-CM	Diagnosis
295.14	Disorganized schizophrenia, chronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.13	Disorganized schizophrenia, subchronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.12	Disorganized schizophrenia, chronic condition	ICD-9-CM	Diagnosis
295.15	Disorganized schizophrenia, in remission	ICD-9-CM	Diagnosis
295.11	Disorganized schizophrenia, subchronic condition	ICD-9-CM	Diagnosis
295.10	Disorganized schizophrenia, unspecified condition	ICD-9-CM	Diagnosis
298.1	Excitative type psychosis	ICD-9-CM	Diagnosis
295.54	Latent schizophrenia, chronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.53	Latent schizophrenia, subchronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.52	Latent schizophrenia, chronic condition	ICD-9-CM	Diagnosis
295.51	Latent schizophrenia, subchronic condition	ICD-9-CM	Diagnosis
295.50	Latent schizophrenia, unspecified condition	ICD-9-CM	Diagnosis
295.55	Latent schizophrenia, in remission	ICD-9-CM	Diagnosis
295.84	Other specified types of schizophrenia, chronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.83	Other specified types of schizophrenia, subchronic condition with acute exacerbation	ICD-9-CM	Diagnosis
298.8	Other and unspecified reactive psychosis	ICD-9-CM	Diagnosis
295.82	Other specified types of schizophrenia, chronic condition	ICD-9-CM	Diagnosis
295.81	Other specified types of schizophrenia, subchronic condition	ICD-9-CM	Diagnosis
295.80	Other specified types of schizophrenia, unspecified condition	ICD-9-CM	Diagnosis
297.8	Other specified paranoid states	ICD-9-CM	Diagnosis
295.85	Other specified types of schizophrenia, in remission	ICD-9-CM	Diagnosis
295.34	Paranoid schizophrenia, chronic condition with acute exacerbation	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
295.33	Paranoid schizophrenia, subchronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.32	Paranoid schizophrenia, chronic condition	ICD-9-CM	Diagnosis
295.35	Paranoid schizophrenia, in remission	ICD-9-CM	Diagnosis
295.31	Paranoid schizophrenia, subchronic condition	ICD-9-CM	Diagnosis
295.30	Paranoid schizophrenia, unspecified condition	ICD-9-CM	Diagnosis
297.0	Paranoid state, simple	ICD-9-CM	Diagnosis
297.2	Paraphrenia	ICD-9-CM	Diagnosis
298.4	Psychogenic paranoid psychosis	ICD-9-CM	Diagnosis
293.82	Psychotic disorder with hallucinations in conditions classified elsewhere	ICD-9-CM	Diagnosis
293.81	Psychotic disorder with delusions in conditions classified elsewhere	ICD-9-CM	Diagnosis
298.2	Reactive confusion	ICD-9-CM	Diagnosis
295.64	Schizophrenic disorders, residual type, chronic with acute exacerbation	ICD-9-CM	Diagnosis
295.63	Schizophrenic disorders, residual type, subchronic with acute exacerbation	ICD-9-CM	Diagnosis
295.73	Schizoaffective disorder, subchronic with acute exacerbation	ICD-9-CM	Diagnosis
295.74	Schizoaffective disorder, chronic with acute exacerbation	ICD-9-CM	Diagnosis
295.72	Schizoaffective disorder, chronic	ICD-9-CM	Diagnosis
295.75	Schizoaffective disorder, in remission	ICD-9-CM	Diagnosis
295.71	Schizoaffective disorder, subchronic	ICD-9-CM	Diagnosis
295.70	Schizoaffective disorder, unspecified	ICD-9-CM	Diagnosis
295.62	Schizophrenic disorders, residual type, chronic	ICD-9-CM	Diagnosis
295.65	Schizophrenic disorders, residual type, in remission	ICD-9-CM	Diagnosis
295.61	Schizophrenic disorders, residual type, subchronic	ICD-9-CM	Diagnosis
295.60	Schizophrenic disorders, residual type, unspecified	ICD-9-CM	Diagnosis
295.43	Schizophreniform disorder, subchronic with acute exacerbation	ICD-9-CM	Diagnosis
295.44	Schizophreniform disorder, chronic with acute exacerbation	ICD-9-CM	Diagnosis
295.42	Schizophreniform disorder, chronic	ICD-9-CM	Diagnosis
295.45	Schizophreniform disorder, in remission	ICD-9-CM	Diagnosis
295.41	Schizophreniform disorder, subchronic	ICD-9-CM	Diagnosis
295.40	Schizophreniform disorder, unspecified	ICD-9-CM	Diagnosis
297.3	Shared psychotic disorder	ICD-9-CM	Diagnosis
295.04	Simple schizophrenia, chronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.03	Simple schizophrenia, subchronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.02	Simple schizophrenia, chronic condition	ICD-9-CM	Diagnosis
295.01	Simple schizophrenia, subchronic condition	ICD-9-CM	Diagnosis
295.00	Simple schizophrenia, unspecified condition	ICD-9-CM	Diagnosis
295.05	Simple schizophrenia, in remission	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
295.94	Unspecified schizophrenia, chronic condition with acute exacerbation	ICD-9-CM	Diagnosis
295.93	Unspecified schizophrenia, subchronic condition with acute exacerbation	ICD-9-CM	Diagnosis
297.9	Unspecified paranoid state	ICD-9-CM	Diagnosis
298.9	Unspecified psychosis	ICD-9-CM	Diagnosis
295.92	Unspecified schizophrenia, chronic condition	ICD-9-CM	Diagnosis
295.95	Unspecified schizophrenia, in remission	ICD-9-CM	Diagnosis
295.91	Unspecified schizophrenia, subchronic condition	ICD-9-CM	Diagnosis
295.90	Unspecified schizophrenia, unspecified condition	ICD-9-CM	Diagnosis
	Substance Use Disorder		
291	Alcohol-induced mental disorders	ICD-9-CM	Diagnosis
291.1	Alcohol-induced persisting amnestic disorder	ICD-9-CM	Diagnosis
291.2	Alcohol-induced persisting dementia	ICD-9-CM	Diagnosis
291.3	Alcohol-induced psychotic disorder with hallucinations	ICD-9-CM	Diagnosis
291.4	Idiosyncratic alcohol intoxication	ICD-9-CM	Diagnosis
291.5	Alcohol-induced psychotic disorder with delusions	ICD-9-CM	Diagnosis
291.8	Other specified alcohol-induced mental disorders	ICD-9-CM	Diagnosis
291.81	Alcohol withdrawal	ICD-9-CM	Diagnosis
291.82	Alcohol induced sleep disorders	ICD-9-CM	Diagnosis
291.89	Other specified alcohol-induced mental disorders	ICD-9-CM	Diagnosis
291.9	Unspecified alcohol-induced mental disorders	ICD-9-CM	Diagnosis
292	Drug-induced mental disorders	ICD-9-CM	Diagnosis
292.11	Drug-induced psychotic disorder with delusions	ICD-9-CM	Diagnosis
292.12	Drug-induced psychotic disorder with hallucinations	ICD-9-CM	Diagnosis
292.2	Pathological drug intoxication	ICD-9-CM	Diagnosis
292.81	Drug-induced delirium	ICD-9-CM	Diagnosis
292.82	Drug-induced persisting dementia	ICD-9-CM	Diagnosis
292.84	Drug-induced mood disorder	ICD-9-CM	Diagnosis
292.85	Drug induced sleep disorders	ICD-9-CM	Diagnosis
292.89	Other specified drug-induced mental disorder	ICD-9-CM	Diagnosis
292.9	Unspecified drug-induced mental disorder	ICD-9-CM	Diagnosis
303.00	Acute alcoholic intoxication, unspecified	ICD-9-CM	Diagnosis
303.01	Acute alcoholic intoxication, continuous	ICD-9-CM	Diagnosis
303.02	Acute alcoholic intoxication, episodic	ICD-9-CM	Diagnosis
303.03	Acute alcoholic intoxication, in remission	ICD-9-CM	Diagnosis
303.90	Other and unspecified alcohol dependence, unspecified	ICD-9-CM	Diagnosis
303.91	Other and unspecified alcohol dependence, continuous	ICD-9-CM	Diagnosis
303.92	Other and unspecified alcohol dependence, episodic	ICD-9-CM	Diagnosis
303.93	Other and unspecified alcohol dependence, in remission	ICD-9-CM	Diagnosis
304.0	Opioid type dependence	ICD-9-CM	Diagnosis
304.00	Opioid type dependence, unspecified	ICD-9-CM	Diagnosis
304.01	Opioid type dependence, continuous	ICD-9-CM	Diagnosis
304.02	Opioid type dependence, episodic	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
304.03	Opioid type dependence, in remission	ICD-9-CM	Diagnosis
304.10	Sedative, hypnotic or anxiolytic dependence, unspecified	ICD-9-CM	Diagnosis
304.11	Sedative, hypnotic or anxiolytic dependence, continuous	ICD-9-CM	Diagnosis
304.12	Sedative, hypnotic or anxiolytic dependence, episodic	ICD-9-CM	Diagnosis
304.13	Sedative, hypnotic or anxiolytic dependence, in remission	ICD-9-CM	Diagnosis
304.20	Cocaine dependence, unspecified	ICD-9-CM	Diagnosis
304.21	Cocaine dependence, continuous	ICD-9-CM	Diagnosis
304.22	Cocaine dependence, episodic	ICD-9-CM	Diagnosis
304.23	Cocaine dependence, in remission	ICD-9-CM	Diagnosis
304.30	Cannabis dependence, unspecified	ICD-9-CM	Diagnosis
304.31	Cannabis dependence, continuous	ICD-9-CM	Diagnosis
304.32	Cannabis dependence, episodic	ICD-9-CM	Diagnosis
304.33	Cannabis dependence, in remission	ICD-9-CM	Diagnosis
304.40	Amphetamine and other psychostimulant dependence, unspecified	ICD-9-CM	Diagnosis
304.41	Amphetamine and other psychostimulant dependence, continuous	ICD-9-CM	Diagnosis
304.42	Amphetamine and other psychostimulant dependence, episodic	ICD-9-CM	Diagnosis
304.43	Amphetamine and other psychostimulant dependence, in remission	ICD-9-CM	Diagnosis
304.60	Other specified drug dependence, unspecified	ICD-9-CM	Diagnosis
304.61	Other specified drug dependence, continuous	ICD-9-CM	Diagnosis
304.62	Other specified drug dependence, episodic	ICD-9-CM	Diagnosis
304.63	Other specified drug dependence, in remission	ICD-9-CM	Diagnosis
304.7	Combinations of opioid type drug with any other drug dependence	ICD-9-CM	Diagnosis
304.70	Combinations of opioid type drug with any other drug dependence, unspecified	ICD-9-CM	Diagnosis
304.71	Combinations of opioid type drug with any other drug dependence, continuous	ICD-9-CM	Diagnosis
304.72	Combinations of opioid type drug with any other drug dependence, episodic	ICD-9-CM	Diagnosis
304.73	Combinations of opioid type drug with any other drug dependence, in remission	ICD-9-CM	Diagnosis
304.80	Combinations of drug dependence excluding opioid type drug, unspecified	ICD-9-CM	Diagnosis
304.81	Combinations of drug dependence excluding opioid type drug, continuous	ICD-9-CM	Diagnosis
304.82	Combinations of drug dependence excluding opioid type drug, episodic	ICD-9-CM	Diagnosis
304.83	Combinations of drug dependence excluding opioid type drug, in remission	ICD-9-CM	Diagnosis
304.90	Unspecified drug dependence, unspecified	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
304.91	Unspecified drug dependence, continuous	ICD-9-CM	Diagnosis
304.92	Unspecified drug dependence, episodic	ICD-9-CM	Diagnosis
304.93	Unspecified drug dependence, in remission	ICD-9-CM	Diagnosis
305.00	Nondependent alcohol abuse, unspecified	ICD-9-CM	Diagnosis
305.01	Nondependent alcohol abuse, continuous	ICD-9-CM	Diagnosis
305.02	Nondependent alcohol abuse, episodic	ICD-9-CM	Diagnosis
305.03	Nondependent alcohol abuse, in remission	ICD-9-CM	Diagnosis
305.20	Nondependent cannabis abuse, unspecified	ICD-9-CM	Diagnosis
305.21	Nondependent cannabis abuse, continuous	ICD-9-CM	Diagnosis
305.22	Nondependent cannabis abuse, episodic	ICD-9-CM	Diagnosis
305.23	Nondependent cannabis abuse, in remission	ICD-9-CM	Diagnosis
305.30	Nondependent hallucinogen abuse, unspecified	ICD-9-CM	Diagnosis
305.31	Nondependent hallucinogen abuse, continuous	ICD-9-CM	Diagnosis
305.32	Nondependent hallucinogen abuse, episodic	ICD-9-CM	Diagnosis
305.33	Nondependent hallucinogen abuse, in remission	ICD-9-CM	Diagnosis
305.40	Nondependent sedative, hypnotic or anxiolytic abuse, unspecified	ICD-9-CM	Diagnosis
305.41	Nondependent sedative hypnotic or anxiolytic abuse, continuous	ICD-9-CM	Diagnosis
305.42	Nondependent sedative, hypnotic or anxiolytic abuse, episodic	ICD-9-CM	Diagnosis
305.43	Nondependent sedative, hypnotic or anxiolytic abuse, in remission	ICD-9-CM	Diagnosis
305.5	Nondependent opioid abuse	ICD-9-CM	Diagnosis
305.50	Nondependent opioid abuse, unspecified	ICD-9-CM	Diagnosis
305.51	Nondependent opioid abuse, continuous	ICD-9-CM	Diagnosis
305.52	Nondependent opioid abuse, episodic	ICD-9-CM	Diagnosis
305.53	Nondependent opioid abuse, in remission	ICD-9-CM	Diagnosis
305.60	Nondependent cocaine abuse, unspecified	ICD-9-CM	Diagnosis
305.61	Nondependent cocaine abuse, continuous	ICD-9-CM	Diagnosis
305.62	Nondependent cocaine abuse, episodic	ICD-9-CM	Diagnosis
305.63	Nondependent cocaine abuse, in remission	ICD-9-CM	Diagnosis
305.90	Other, mixed, or unspecified nondependent drug abuse, unspecified	ICD-9-CM	Diagnosis
305.91	Other, mixed, or unspecified nondependent drug abuse, continuous	ICD-9-CM	Diagnosis
305.92	Other, mixed, or unspecified nondependent drug abuse, episodic	ICD-9-CM	Diagnosis
305.93	Other, mixed, or unspecified nondependent drug abuse, in remission	ICD-9-CM	Diagnosis
357.5	Alcoholic polyneuropathy	ICD-9-CM	Diagnosis
425.5	Alcoholic cardiomyopathy	ICD-9-CM	Diagnosis
535.30	Alcoholic gastritis without mention of hemorrhage	ICD-9-CM	Diagnosis
535.31	Alcoholic gastritis with hemorrhage	ICD-9-CM	Diagnosis
571	Chronic liver disease and cirrhosis	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
571.1	Acute alcoholic hepatitis	ICD-9-CM	Diagnosis
571.3	Unspecified alcoholic liver damage	ICD-9-CM	Diagnosis
648.30	Maternal drug dependence complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care	ICD-9-CM	Diagnosis
648.31	Maternal drug dependence, with delivery	ICD-9-CM	Diagnosis
648.32	Maternal drug dependence, with delivery, with current postpartum complication	ICD-9-CM	Diagnosis
648.33	Maternal drug dependence, antepartum	ICD-9-CM	Diagnosis
648.34	Maternal drug dependence complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	ICD-9-CM	Diagnosis
760.72	Noxious influences affecting fetus or newborn via placenta or breast milk, narcotics	ICD-9-CM	Diagnosis
965	Poisoning by analgesics, antipyretics, and antirheumatics	ICD-9-CM	Diagnosis
965.0	Poisoning by opiates and related narcotics	ICD-9-CM	Diagnosis
965.00	Poisoning by opium (alkaloids), unspecified	ICD-9-CM	Diagnosis
965.01	Poisoning by heroin	ICD-9-CM	Diagnosis
965.02	Poisoning by methadone	ICD-9-CM	Diagnosis
965.09	Poisoning by opiates and related narcotics, other	ICD-9-CM	Diagnosis
968.5	Poisoning by other central nervous system depressants and anesthetics, Surface (topical) and infiltration anesthetics	ICD-9-CM	Diagnosis
969.6	Poisoning by psychodysleptics (hallucinogens)	ICD-9-CM	Diagnosis
970.1	Poisoning by opiate antagonists	ICD-9-CM	Diagnosis
E85.00	Accidental poisoning by heroin	ICD-9-CM	Diagnosis
E85.01	Accidental poisoning by methadone	ICD-9-CM	Diagnosis
E85.02	Accidental poisoning by other opiates and related narcotics	ICD-9-CM	Diagnosis
E860.0	Accidental poisoning by alcoholic beverages	ICD-9-CM	Diagnosis
E93.50	Heroin causing adverse effect in therapeutic use	ICD-9-CM	Diagnosis
E93.51	Methadone causing averse effect in therapeutic use	ICD-9-CM	Diagnosis
E93.52	Other opiates and related narcotics causing adverse effect in therapeutic use	ICD-9-CM	Diagnosis
E935.0	Heroin causing adverse effect in therapeutic use	ICD-9-CM	Diagnosis
E935.1	Methadone causing averse effect in therapeutic use	ICD-9-CM	Diagnosis
E935.2	Other opiates and related narcotics causing adverse effect in therapeutic use	ICD-9-CM	Diagnosis
E938.5	Surface and infiltration anesthetics causing adverse effect in therapeutic use	ICD-9-CM	Diagnosis
E939.6	Psychodysleptics (hallucinogens) causing adverse effect in therapeutic use	ICD-9-CM	Diagnosis
E94.01	Opiate antagonists causing adverse effect in therapeutic use	ICD-9-CM	Diagnosis
E940.1	Opiate antagonists causing adverse effect in therapeutic use	ICD-9-CM	Diagnosis
V65.42	Counseling on substance use and abuse	ICD-9-CM	Diagnosis
F10.10	Alcohol abuse, uncomplicated	ICD-10-CM	Diagnosis
F10.11	Alcohol abuse, in remission	ICD-10-CM	Diagnosis
F10.120	Alcohol abuse with intoxication, uncomplicated	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
F10.129	Alcohol abuse with intoxication, unspecified	ICD-10-CM	Diagnosis
F10.14	Alcohol abuse with alcohol-induced mood disorder	ICD-10-CM	Diagnosis
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F10.180	Alcohol abuse with alcohol-induced anxiety disorder	ICD-10-CM	Diagnosis
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction	ICD-10-CM	Diagnosis
F10.182	Alcohol abuse with alcohol-induced sleep disorder	ICD-10-CM	Diagnosis
F10.188	Alcohol abuse with other alcohol-induced disorder	ICD-10-CM	Diagnosis
F10.19	Alcohol abuse with unspecified alcohol-induced disorder	ICD-10-CM	Diagnosis
F10.20	Alcohol dependence, uncomplicated	ICD-10-CM	Diagnosis
F10.21	Alcohol dependence, in remission	ICD-10-CM	Diagnosis
F10.220	Alcohol dependence with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F10.229	Alcohol dependence with intoxication, unspecified	ICD-10-CM	Diagnosis
F10.230	Alcohol dependence with withdrawal, uncomplicated	ICD-10-CM	Diagnosis
F10.232	Alcohol dependence with withdrawal with perceptual disturbance	ICD-10-CM	Diagnosis
F10.239	Alcohol dependence with withdrawal, unspecified	ICD-10-CM	Diagnosis
F10.24	Alcohol dependence with alcohol-induced mood disorder	ICD-10-CM	Diagnosis
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder	ICD-10-CM	Diagnosis
F10.27	Alcohol dependence with alcohol-induced persisting dementia	ICD-10-CM	Diagnosis
F10.280	Alcohol dependence with alcohol-induced anxiety disorder	ICD-10-CM	Diagnosis
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction	ICD-10-CM	Diagnosis
F10.282	Alcohol dependence with alcohol-induced sleep disorder	ICD-10-CM	Diagnosis
F10.288	Alcohol dependence with other alcohol-induced disorder	ICD-10-CM	Diagnosis
F10.29	Alcohol dependence with unspecified alcohol-induced disorder	ICD-10-CM	Diagnosis
F10.920	Alcohol use, unspecified with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F10.929	Alcohol use, unspecified with intoxication, unspecified	ICD-10-CM	Diagnosis
F10.94	Alcohol use, unspecified with alcohol-induced mood disorder	ICD-10-CM	Diagnosis
F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F10.959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder	ICD-10-CM	Diagnosis
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia	ICD-10-CM	Diagnosis
F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder	ICD-10-CM	Diagnosis
F10.981	Alcohol use, unspecified with alcohol-induced sexual dysfunction	ICD-10-CM	Diagnosis
F10.982	Alcohol use, unspecified with alcohol-induced sleep disorder	ICD-10-CM	Diagnosis
F10.988	Alcohol use, unspecified with other alcohol-induced disorder	ICD-10-CM	Diagnosis
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder	ICD-10-CM	Diagnosis
F11.10	Opioid abuse, uncomplicated	ICD-10-CM	Diagnosis
F11.11	Opioid abuse, in remission	ICD-10-CM	Diagnosis
F11.120	Opioid abuse with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F11.121	Opioid abuse with intoxication delirium	ICD-10-CM	Diagnosis
F11.122	Opioid abuse with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F11.129	Opioid abuse with intoxication, unspecified	ICD-10-CM	Diagnosis
F11.13	Opioid abuse with withdrawal	ICD-10-CM	Diagnosis
F11.14	Opioid abuse with opioid-induced mood disorder	ICD-10-CM	Diagnosis
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F11.181	Opioid abuse with opioid-induced sexual dysfunction	ICD-10-CM	Diagnosis
F11.182	Opioid abuse with opioid-induced sleep disorder	ICD-10-CM	Diagnosis
F11.188	Opioid abuse with other opioid-induced disorder	ICD-10-CM	Diagnosis
F11.19	Opioid abuse with unspecified opioid-induced disorder	ICD-10-CM	Diagnosis
F11.20	Opioid dependence, uncomplicated	ICD-10-CM	Diagnosis
F11.21	Opioid dependence, in remission	ICD-10-CM	Diagnosis
F11.220	Opioid dependence with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F11.221	Opioid dependence with intoxication delirium	ICD-10-CM	Diagnosis
F11.222	Opioid dependence with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F11.229	Opioid dependence with intoxication, unspecified	ICD-10-CM	Diagnosis
F11.23	Opioid dependence with withdrawal	ICD-10-CM	Diagnosis
F11.24	Opioid dependence with opioid-induced mood disorder	ICD-10-CM	Diagnosis
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F11.281	Opioid dependence with opioid-induced sexual dysfunction	ICD-10-CM	Diagnosis
F11.282	Opioid dependence with opioid-induced sleep disorder	ICD-10-CM	Diagnosis
F11.288	Opioid dependence with other opioid-induced disorder	ICD-10-CM	Diagnosis
F11.29	Opioid dependence with unspecified opioid-induced disorder	ICD-10-CM	Diagnosis
F11.90	Opioid use, unspecified, uncomplicated	ICD-10-CM	Diagnosis
F11.920	Opioid use, unspecified with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F11.921	Opioid use, unspecified with intoxication delirium	ICD-10-CM	Diagnosis
F11.922	Opioid use, unspecified with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F11.929	Opioid use, unspecified with intoxication, unspecified	ICD-10-CM	Diagnosis
F11.93	Opioid use, unspecified with withdrawal	ICD-10-CM	Diagnosis
F11.94	Opioid use, unspecified with opioid-induced mood disorder	ICD-10-CM	Diagnosis
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F11.981	Opioid use, unspecified with opioid-induced sexual dysfunction	ICD-10-CM	Diagnosis
F11.982	Opioid use, unspecified with opioid-induced sleep disorder	ICD-10-CM	Diagnosis
F11.988	Opioid use, unspecified with other opioid-induced disorder	ICD-10-CM	Diagnosis
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder	ICD-10-CM	Diagnosis
F12.10	Cannabis abuse, uncomplicated	ICD-10-CM	Diagnosis
F12.11	Cannabis abuse, in remission	ICD-10-CM	Diagnosis
F12.120	Cannabis abuse with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F12.121	Cannabis abuse with intoxication delirium	ICD-10-CM	Diagnosis
F12.122	Cannabis abuse with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F12.129	Cannabis abuse with intoxication, unspecified	ICD-10-CM	Diagnosis
F12.150	Cannabis abuse with psychotic disorder with delusions	ICD-10-CM	Diagnosis
F12.151	Cannabis abuse with psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F12.159	Cannabis abuse with psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F12.180	Cannabis abuse with cannabis-induced anxiety disorder	ICD-10-CM	Diagnosis
F12.188	Cannabis abuse with other cannabis-induced disorder	ICD-10-CM	Diagnosis
F12.19	Cannabis abuse with unspecified cannabis-induced disorder	ICD-10-CM	Diagnosis
F12.20	Cannabis dependence, uncomplicated	ICD-10-CM	Diagnosis
F12.21	Cannabis dependence, in remission	ICD-10-CM	Diagnosis
F12.220	Cannabis dependence with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F12.221	Cannabis dependence with intoxication delirium	ICD-10-CM	Diagnosis
F12.222	Cannabis dependence with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F12.229	Cannabis dependence with intoxication, unspecified	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F12.250	Cannabis dependence with psychotic disorder with delusions	ICD-10-CM	Diagnosis
F12.251	Cannabis dependence with psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F12.259	Cannabis dependence with psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F12.280	Cannabis dependence with cannabis-induced anxiety disorder	ICD-10-CM	Diagnosis
F12.288	Cannabis dependence with other cannabis-induced disorder	ICD-10-CM	Diagnosis
F12.29	Cannabis dependence with unspecified cannabis-induced disorder	ICD-10-CM	Diagnosis
F12.90	Cannabis use, unspecified, uncomplicated	ICD-10-CM	Diagnosis
F12.920	Cannabis use, unspecified with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F12.921	Cannabis use, unspecified with intoxication delirium	ICD-10-CM	Diagnosis
F12.922	Cannabis use, unspecified with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F12.929	Cannabis use, unspecified with intoxication, unspecified	ICD-10-CM	Diagnosis
F12.950	Cannabis use, unspecified with psychotic disorder with delusions	ICD-10-CM	Diagnosis
F12.951	Cannabis use, unspecified with psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F12.959	Cannabis use, unspecified with psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F12.980	Cannabis use, unspecified with anxiety disorder	ICD-10-CM	Diagnosis
F12.988	Cannabis use, unspecified with other cannabis-induced disorder	ICD-10-CM	Diagnosis
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder	ICD-10-CM	Diagnosis
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated	ICD-10-CM	Diagnosis
F13.11	Sedative, hypnotic or anxiolytic abuse, in remission	ICD-10-CM	Diagnosis
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium	ICD-10-CM	Diagnosis
F13.129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified	ICD-10-CM	Diagnosis
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder	ICD-10-CM	Diagnosis
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder	ICD-10-CM	Diagnosis
F13.181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder	ICD-10-CM	Diagnosis
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder	ICD-10-CM	Diagnosis
F13.19	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder	ICD-10-CM	Diagnosis
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated	ICD-10-CM	Diagnosis
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission	ICD-10-CM	Diagnosis
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium	ICD-10-CM	Diagnosis
F13.229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified	ICD-10-CM	Diagnosis
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated	ICD-10-CM	Diagnosis
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium	ICD-10-CM	Diagnosis
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance	ICD-10-CM	Diagnosis
F13.239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified	ICD-10-CM	Diagnosis
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder	ICD-10-CM	Diagnosis
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder	ICD-10-CM	Diagnosis
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia	ICD-10-CM	Diagnosis
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder	ICD-10-CM	Diagnosis
F13.281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction	ICD-10-CM	Diagnosis
F13.282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder	ICD-10-CM	Diagnosis
F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F13.29	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder	ICD-10-CM	Diagnosis
F13.90	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated	ICD-10-CM	Diagnosis
F13.920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F13.921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium	ICD-10-CM	Diagnosis
F13.929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified	ICD-10-CM	Diagnosis
F13.94	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder	ICD-10-CM	Diagnosis
F13.950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F13.951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F13.959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia	ICD-10-CM	Diagnosis
F13.980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder	ICD-10-CM	Diagnosis
F13.981	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction	ICD-10-CM	Diagnosis
F13.982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder	ICD-10-CM	Diagnosis
F13.988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder	ICD-10-CM	Diagnosis
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder	ICD-10-CM	Diagnosis
F14.10	Cocaine abuse, uncomplicated	ICD-10-CM	Diagnosis
F14.11	Cocaine abuse, in remission	ICD-10-CM	Diagnosis
F14.120	Cocaine abuse with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F14.121	Cocaine abuse with intoxication with delirium	ICD-10-CM	Diagnosis
F14.122	Cocaine abuse with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F14.129	Cocaine abuse with intoxication, unspecified	ICD-10-CM	Diagnosis
F14.14	Cocaine abuse with cocaine-induced mood disorder	ICD-10-CM	Diagnosis
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F14.180	Cocaine abuse with cocaine-induced anxiety disorder	ICD-10-CM	Diagnosis
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction	ICD-10-CM	Diagnosis
F14.182	Cocaine abuse with cocaine-induced sleep disorder	ICD-10-CM	Diagnosis
F14.188	Cocaine abuse with other cocaine-induced disorder	ICD-10-CM	Diagnosis
F14.19	Cocaine abuse with unspecified cocaine-induced disorder	ICD-10-CM	Diagnosis
F14.20	Cocaine dependence, uncomplicated	ICD-10-CM	Diagnosis
F14.21	Cocaine dependence, in remission	ICD-10-CM	Diagnosis
F14.220	Cocaine dependence with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F14.221	Cocaine dependence with intoxication delirium	ICD-10-CM	Diagnosis
F14.222	Cocaine dependence with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F14.229	Cocaine dependence with intoxication, unspecified	ICD-10-CM	Diagnosis
F14.23	Cocaine dependence with withdrawal	ICD-10-CM	Diagnosis
F14.24	Cocaine dependence with cocaine-induced mood disorder	ICD-10-CM	Diagnosis
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F14.280	Cocaine dependence with cocaine-induced anxiety disorder	ICD-10-CM	Diagnosis
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction	ICD-10-CM	Diagnosis
F14.282	Cocaine dependence with cocaine-induced sleep disorder	ICD-10-CM	Diagnosis
F14.288	Cocaine dependence with other cocaine-induced disorder	ICD-10-CM	Diagnosis
F14.29	Cocaine dependence with unspecified cocaine-induced disorder	ICD-10-CM	Diagnosis
F14.90	Cocaine use, unspecified, uncomplicated	ICD-10-CM	Diagnosis
F14.920	Cocaine use, unspecified with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F14.921	Cocaine use, unspecified with intoxication delirium	ICD-10-CM	Diagnosis
F14.922	Cocaine use, unspecified with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F14.929	Cocaine use, unspecified with intoxication, unspecified	ICD-10-CM	Diagnosis
F14.94	Cocaine use, unspecified with cocaine-induced mood disorder	ICD-10-CM	Diagnosis
F14.950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F14.951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F14.959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F14.980	Cocaine use, unspecified with cocaine-induced anxiety disorder	ICD-10-CM	Diagnosis
F14.981	Cocaine use, unspecified with cocaine-induced sexual dysfunction	ICD-10-CM	Diagnosis
F14.982	Cocaine use, unspecified with cocaine-induced sleep disorder	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F14.988	Cocaine use, unspecified with other cocaine-induced disorder	ICD-10-CM	Diagnosis
F14.99	Cocaine use, unspecified with unspecified cocaine-induced disorder	ICD-10-CM	Diagnosis
F15.121	Other stimulant abuse with intoxication delirium	ICD-10-CM	Diagnosis
F15.122	Other stimulant abuse with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F15.129	Other stimulant abuse with intoxication, unspecified	ICD-10-CM	Diagnosis
F15.14	Other stimulant abuse with stimulant-induced mood disorder	ICD-10-CM	Diagnosis
F15.150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F15.151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder	ICD-10-CM	Diagnosis
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction	ICD-10-CM	Diagnosis
F15.182	Other stimulant abuse with stimulant-induced sleep disorder	ICD-10-CM	Diagnosis
F15.188	Other stimulant abuse with other stimulant-induced disorder	ICD-10-CM	Diagnosis
F15.19	Other stimulant abuse with unspecified stimulant-induced disorder	ICD-10-CM	Diagnosis
F15.20	Other stimulant dependence, uncomplicated	ICD-10-CM	Diagnosis
F15.21	Other stimulant dependence, in remission	ICD-10-CM	Diagnosis
F15.220	Other stimulant dependence with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F15.221	Other stimulant dependence with intoxication delirium	ICD-10-CM	Diagnosis
F15.222	Other stimulant dependence with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F15.229	Other stimulant dependence with intoxication, unspecified	ICD-10-CM	Diagnosis
F15.23	Other stimulant dependence with withdrawal	ICD-10-CM	Diagnosis
F15.24	Other stimulant dependence with stimulant-induced mood disorder	ICD-10-CM	Diagnosis
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder	ICD-10-CM	Diagnosis
F15.281	Other stimulant dependence with stimulant-induced sexual dysfunction	ICD-10-CM	Diagnosis
F15.282	Other stimulant dependence with stimulant-induced sleep disorder	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F15.288	Other stimulant dependence with other stimulant-induced disorder	ICD-10-CM	Diagnosis
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder	ICD-10-CM	Diagnosis
F15.920	Other stimulant use, unspecified with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F15.921	Other stimulant use, unspecified with intoxication delirium	ICD-10-CM	Diagnosis
F15.922	Other stimulant use, unspecified with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F15.929	Other stimulant use, unspecified with intoxication, unspecified	ICD-10-CM	Diagnosis
F15.94	Other stimulant use, unspecified with stimulant-induced mood disorder	ICD-10-CM	Diagnosis
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F15.951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F15.959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F15.980	Other stimulant use, unspecified with stimulant-induced anxiety disorder	ICD-10-CM	Diagnosis
F15.981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction	ICD-10-CM	Diagnosis
F15.982	Other stimulant use, unspecified with stimulant-induced sleep disorder	ICD-10-CM	Diagnosis
F15.988	Other stimulant use, unspecified with other stimulant-induced disorder	ICD-10-CM	Diagnosis
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder	ICD-10-CM	Diagnosis
F16.10	Hallucinogen abuse, uncomplicated	ICD-10-CM	Diagnosis
F16.11	Hallucinogen abuse, in remission	ICD-10-CM	Diagnosis
F16.120	Hallucinogen abuse with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F16.121	Hallucinogen abuse with intoxication with delirium	ICD-10-CM	Diagnosis
F16.122	Hallucinogen abuse with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F16.129	Hallucinogen abuse with intoxication, unspecified	ICD-10-CM	Diagnosis
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder	ICD-10-CM	Diagnosis
F16.150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F16.151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)	ICD-10-CM	Diagnosis
F16.188	Hallucinogen abuse with other hallucinogen-induced disorder	ICD-10-CM	Diagnosis
F16.19	Hallucinogen abuse with unspecified hallucinogen-induced disorder	ICD-10-CM	Diagnosis
F16.220	Hallucinogen dependence with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F16.221	Hallucinogen dependence with intoxication with delirium	ICD-10-CM	Diagnosis
F16.229	Hallucinogen dependence with intoxication, unspecified	ICD-10-CM	Diagnosis
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder	ICD-10-CM	Diagnosis
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder	ICD-10-CM	Diagnosis
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)	ICD-10-CM	Diagnosis
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder	ICD-10-CM	Diagnosis
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder	ICD-10-CM	Diagnosis
F16.90	Hallucinogen use, unspecified, uncomplicated	ICD-10-CM	Diagnosis
F16.920	Hallucinogen use, unspecified with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F16.921	Hallucinogen use, unspecified with intoxication with delirium	ICD-10-CM	Diagnosis
F16.929	Hallucinogen use, unspecified with intoxication, unspecified	ICD-10-CM	Diagnosis
F16.94	Hallucinogen use, unspecified with hallucinogen-induced mood disorder	ICD-10-CM	Diagnosis
F16.950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F16.951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F16.959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F16.980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder	ICD-10-CM	Diagnosis
F16.983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)	ICD-10-CM	Diagnosis
F16.988	Hallucinogen use, unspecified with other hallucinogen-induced disorder	ICD-10-CM	Diagnosis
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
F17.208	Nicotine dependence, unspecified, with other nicotine-induced disorders	ICD-10-CM	Diagnosis
F17.209	Nicotine dependence, unspecified, with unspecified nicotine-induced disorders	ICD-10-CM	Diagnosis
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders	ICD-10-CM	Diagnosis
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders	ICD-10-CM	Diagnosis
F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders	ICD-10-CM	Diagnosis
F17.229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders	ICD-10-CM	Diagnosis
F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders	ICD-10-CM	Diagnosis
F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders	ICD-10-CM	Diagnosis
F18.10	Inhalant abuse, uncomplicated	ICD-10-CM	Diagnosis
F18.11	Inhalant abuse, in remission	ICD-10-CM	Diagnosis
F18.120	Inhalant abuse with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F18.121	Inhalant abuse with intoxication delirium	ICD-10-CM	Diagnosis
F18.129	Inhalant abuse with intoxication, unspecified	ICD-10-CM	Diagnosis
F18.14	Inhalant abuse with inhalant-induced mood disorder	ICD-10-CM	Diagnosis
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F18.17	Inhalant abuse with inhalant-induced dementia	ICD-10-CM	Diagnosis
F18.180	Inhalant abuse with inhalant-induced anxiety disorder	ICD-10-CM	Diagnosis
F18.188	Inhalant abuse with other inhalant-induced disorder	ICD-10-CM	Diagnosis
F18.19	Inhalant abuse with unspecified inhalant-induced disorder	ICD-10-CM	Diagnosis
F18.20	Inhalant dependence, uncomplicated	ICD-10-CM	Diagnosis
F18.21	Inhalant dependence, in remission	ICD-10-CM	Diagnosis
F18.220	Inhalant dependence with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F18.221	Inhalant dependence with intoxication delirium	ICD-10-CM	Diagnosis
F18.229	Inhalant dependence with intoxication, unspecified	ICD-10-CM	Diagnosis
F18.24	Inhalant dependence with inhalant-induced mood disorder	ICD-10-CM	Diagnosis
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F18.27	Inhalant dependence with inhalant-induced dementia	ICD-10-CM	Diagnosis
F18.280	Inhalant dependence with inhalant-induced anxiety disorder	ICD-10-CM	Diagnosis
F18.288	Inhalant dependence with other inhalant-induced disorder	ICD-10-CM	Diagnosis
F18.29	Inhalant dependence with unspecified inhalant-induced disorder	ICD-10-CM	Diagnosis
F18.90	Inhalant use, unspecified, uncomplicated	ICD-10-CM	Diagnosis
F18.920	Inhalant use, unspecified with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F18.921	Inhalant use, unspecified with intoxication with delirium	ICD-10-CM	Diagnosis
F18.929	Inhalant use, unspecified with intoxication, unspecified	ICD-10-CM	Diagnosis
F18.94	Inhalant use, unspecified with inhalant-induced mood disorder	ICD-10-CM	Diagnosis
F18.950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F18.951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F18.959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia	ICD-10-CM	Diagnosis
F18.980	Inhalant use, unspecified with inhalant-induced anxiety disorder	ICD-10-CM	Diagnosis
F18.988	Inhalant use, unspecified with other inhalant-induced disorder	ICD-10-CM	Diagnosis
F18.99	Inhalant use, unspecified with unspecified inhalant-induced disorder	ICD-10-CM	Diagnosis
F19.10	Other psychoactive substance abuse, uncomplicated	ICD-10-CM	Diagnosis
F19.11	Other psychoactive substance abuse, in remission	ICD-10-CM	Diagnosis
F19.121	Other psychoactive substance abuse with intoxication delirium	ICD-10-CM	Diagnosis
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances	ICD-10-CM	Diagnosis
F19.129	Other psychoactive substance abuse with intoxication, unspecified	ICD-10-CM	Diagnosis
F19.14	Other psychoactive substance abuse with psychoactive substance-induced mood disorder	ICD-10-CM	Diagnosis
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia	ICD-10-CM	Diagnosis
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder	ICD-10-CM	Diagnosis
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
F19.182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder	ICD-10-CM	Diagnosis
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder	ICD-10-CM	Diagnosis
F19.19	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder	ICD-10-CM	Diagnosis
F19.20	Other psychoactive substance dependence, uncomplicated	ICD-10-CM	Diagnosis
F19.21	Other psychoactive substance dependence, in remission	ICD-10-CM	Diagnosis
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F19.221	Other psychoactive substance dependence with intoxication delirium	ICD-10-CM	Diagnosis
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F19.229	Other psychoactive substance dependence with intoxication, unspecified	ICD-10-CM	Diagnosis
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated	ICD-10-CM	Diagnosis
F19.231	Other psychoactive substance dependence with withdrawal delirium	ICD-10-CM	Diagnosis
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance	ICD-10-CM	Diagnosis
F19.239	Other psychoactive substance dependence with withdrawal, unspecified	ICD-10-CM	Diagnosis
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder	ICD-10-CM	Diagnosis
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder	ICD-10-CM	Diagnosis
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia	ICD-10-CM	Diagnosis
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder	ICD-10-CM	Diagnosis
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction	ICD-10-CM	Diagnosis
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder	ICD-10-CM	Diagnosis
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder	ICD-10-CM	Diagnosis
F19.920	Other psychoactive substance use, unspecified with intoxication, uncomplicated	ICD-10-CM	Diagnosis
F19.921	Other psychoactive substance use, unspecified with intoxication with delirium	ICD-10-CM	Diagnosis
F19.922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance	ICD-10-CM	Diagnosis
F19.929	Other psychoactive substance use, unspecified with intoxication, unspecified	ICD-10-CM	Diagnosis
F19.94	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder	ICD-10-CM	Diagnosis
F19.950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions	ICD-10-CM	Diagnosis
F19.951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations	ICD-10-CM	Diagnosis
F19.959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified	ICD-10-CM	Diagnosis
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia	ICD-10-CM	Diagnosis
F19.980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder	ICD-10-CM	Diagnosis
F19.981	Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction	ICD-10-CM	Diagnosis
F19.982	Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder	ICD-10-CM	Diagnosis
F19.988	Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder	ICD-10-CM	Diagnosis
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder	ICD-10-CM	Diagnosis
F55.0	Abuse of antacids	ICD-10-CM	Diagnosis
F55.1	Abuse of herbal or folk remedies	ICD-10-CM	Diagnosis
F55.2	Abuse of laxatives	ICD-10-CM	Diagnosis
F55.3	Abuse of steroids or hormones	ICD-10-CM	Diagnosis
F55.4	Abuse of vitamins	ICD-10-CM	Diagnosis
F55.8	Abuse of other non-psychoactive substances	ICD-10-CM	Diagnosis
G62.1	Alcoholic polyneuropathy	ICD-10-CM	Diagnosis
I42.6	Alcoholic cardiomyopathy	ICD-10-CM	Diagnosis
K29.20	Alcoholic gastritis without bleeding	ICD-10-CM	Diagnosis
K29.21	Alcoholic gastritis with bleeding	ICD-10-CM	Diagnosis
K70.10	Alcoholic hepatitis without ascites	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
K70.11	Alcoholic hepatitis with ascites	ICD-10-CM	Diagnosis
K70.40	Alcoholic hepatic failure without coma	ICD-10-CM	Diagnosis
K70.41	Alcoholic hepatic failure with coma	ICD-10-CM	Diagnosis
K70.9	Alcoholic liver disease, unspecified	ICD-10-CM	Diagnosis
O99.320	Drug use complicating pregnancy, unspecified trimester	ICD-10-CM	Diagnosis
O99.321	Drug use complicating pregnancy, first trimester	ICD-10-CM	Diagnosis
O99.322	Drug use complicating pregnancy, second trimester	ICD-10-CM	Diagnosis
O99.323	Drug use complicating pregnancy, third trimester	ICD-10-CM	Diagnosis
O99.324	Drug use complicating childbirth	ICD-10-CM	Diagnosis
O99.325	Drug use complicating the puerperium	ICD-10-CM	Diagnosis
T40.0X1A	Poisoning by opium, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.0X1D	Poisoning by opium, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis
T40.0X1S	Poisoning by opium, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.0X2A	Poisoning by opium, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.0X2D	Poisoning by opium, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.0X2S	Poisoning by opium, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.0X3A	Poisoning by opium, assault, initial encounter	ICD-10-CM	Diagnosis
T40.0X3D	Poisoning by opium, assault, subsequent encounter	ICD-10-CM	Diagnosis
T40.0X3S	Poisoning by opium, assault, sequela	ICD-10-CM	Diagnosis
T40.0X4A	Poisoning by opium, undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.0X4D	Poisoning by opium, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.0X4S	Poisoning by opium, undetermined, sequela	ICD-10-CM	Diagnosis
T40.0X5A	Adverse effect of opium, initial encounter	ICD-10-CM	Diagnosis
T40.0X5D	Adverse effect of opium, subsequent encounter	ICD-10-CM	Diagnosis
T40.0X5S	Adverse effect of opium, sequela	ICD-10-CM	Diagnosis
T40.1X1A	Poisoning by heroin, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.1X1D	Poisoning by heroin, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis
T40.1X1S	Poisoning by heroin, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.1X2A	Poisoning by heroin, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.1X2D	Poisoning by heroin, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.1X2S	Poisoning by heroin, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.1X3A	Poisoning by heroin, assault, initial encounter	ICD-10-CM	Diagnosis
T40.1X3D	Poisoning by heroin, assault, subsequent encounter	ICD-10-CM	Diagnosis
T40.1X3S	Poisoning by heroin, assault, sequela	ICD-10-CM	Diagnosis
T40.1X4A	Poisoning by heroin, undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.1X4D	Poisoning by heroin, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.1X4S	Poisoning by heroin, undetermined, sequela	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
T40.2X1A	Poisoning by other opioids, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.2X1D	Poisoning by other opioids, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis
T40.2X1S	Poisoning by other opioids, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.2X2A	Poisoning by other opioids, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.2X2D	Poisoning by other opioids, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.2X2S	Poisoning by other opioids, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.2X3A	Poisoning by other opioids, assault, initial encounter	ICD-10-CM	Diagnosis
T40.2X3D	Poisoning by other opioids, assault, subsequent encounter	ICD-10-CM	Diagnosis
T40.2X3S	Poisoning by other opioids, assault, sequela	ICD-10-CM	Diagnosis
T40.2X4A	Poisoning by other opioids, undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.2X4D	Poisoning by other opioids, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.2X4S	Poisoning by other opioids, undetermined, sequela	ICD-10-CM	Diagnosis
T40.2X5A	Adverse effect of other opioids, initial encounter	ICD-10-CM	Diagnosis
T40.2X5D	Adverse effect of other opioids, subsequent encounter	ICD-10-CM	Diagnosis
T40.2X5S	Adverse effect of other opioids, sequela	ICD-10-CM	Diagnosis
T40.3X1A	Poisoning by methadone, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.3X1D	Poisoning by methadone, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis
T40.3X1S	Poisoning by methadone, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.3X2A	Poisoning by methadone, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.3X2D	Poisoning by methadone, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.3X2S	Poisoning by methadone, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.3X3A	Poisoning by methadone, assault, initial encounter	ICD-10-CM	Diagnosis
T40.3X3D	Poisoning by methadone, assault, subsequent encounter	ICD-10-CM	Diagnosis
T40.3X3S	Poisoning by methadone, assault, sequela	ICD-10-CM	Diagnosis
T40.3X4A	Poisoning by methadone, undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.3X4D	Poisoning by methadone, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.3X4S	Poisoning by methadone, undetermined, sequela	ICD-10-CM	Diagnosis
T40.3X5A	Adverse effect of methadone, initial encounter	ICD-10-CM	Diagnosis
T40.3X5D	Adverse effect of methadone, subsequent encounter	ICD-10-CM	Diagnosis
T40.3X5S	Adverse effect of methadone, sequela	ICD-10-CM	Diagnosis
T40.411A	Poisoning by fentanyl or fentanyl analogs, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.411D	Poisoning by fentanyl or fentanyl analogs, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
T40.411S	Poisoning by fentanyl or fentanyl analogs, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.412A	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.412D	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.412S	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.413A	Poisoning by fentanyl or fentanyl analogs, assault, initial encounter	ICD-10-CM	Diagnosis
T40.413D	Poisoning by fentanyl or fentanyl analogs, assault, subsequent encounter	ICD-10-CM	Diagnosis
T40.413S	Poisoning by fentanyl or fentanyl analogs, assault, sequela	ICD-10-CM	Diagnosis
T40.414A	Poisoning by fentanyl or fentanyl analogs, undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.414D	Poisoning by fentanyl or fentanyl analogs, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.414S	Poisoning by fentanyl or fentanyl analogs, undetermined, sequela	ICD-10-CM	Diagnosis
T40.415A	Adverse effect of fentanyl or fentanyl analogs, initial encounter	ICD-10-CM	Diagnosis
T40.415D	Adverse effect of fentanyl or fentanyl analogs, subsequent encounter	ICD-10-CM	Diagnosis
T40.415S	Adverse effect of fentanyl or fentanyl analogs, sequela	ICD-10-CM	Diagnosis
T40.421A	Poisoning by tramadol, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.421D	Poisoning by tramadol, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis
T40.421S	Poisoning by tramadol, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.422A	Poisoning by tramadol, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.422D	Poisoning by tramadol, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.422S	Poisoning by tramadol, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.423A	Poisoning by tramadol, assault, initial encounter	ICD-10-CM	Diagnosis
T40.423D	Poisoning by tramadol, assault, subsequent encounter	ICD-10-CM	Diagnosis
T40.423S	Poisoning by tramadol, assault, sequela	ICD-10-CM	Diagnosis
T40.424A	Poisoning by tramadol, undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.424D	Poisoning by tramadol, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.424S	Poisoning by tramadol, undetermined, sequela	ICD-10-CM	Diagnosis
T40.425A	Adverse effect of tramadol, initial encounter	ICD-10-CM	Diagnosis
T40.425D	Adverse effect of tramadol, subsequent encounter	ICD-10-CM	Diagnosis
T40.425S	Adverse effect of tramadol, sequela	ICD-10-CM	Diagnosis
T40.491A	Poisoning by other synthetic narcotics, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
T40.491D	Poisoning by other synthetic narcotics, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis
T40.491S	Poisoning by other synthetic narcotics, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.492A	Poisoning by other synthetic narcotics, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.492D	Poisoning by other synthetic narcotics, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.492S	Poisoning by other synthetic narcotics, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.493A	Poisoning by other synthetic narcotics, assault, initial encounter	ICD-10-CM	Diagnosis
T40.493D	Poisoning by other synthetic narcotics, assault, subsequent encounter	ICD-10-CM	Diagnosis
T40.493S	Poisoning by other synthetic narcotics, assault, sequela	ICD-10-CM	Diagnosis
T40.494A	Poisoning by other synthetic narcotics, undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.494D	Poisoning by other synthetic narcotics, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.494S	Poisoning by other synthetic narcotics, undetermined, sequela	ICD-10-CM	Diagnosis
T40.495A	Adverse effect of other synthetic narcotics, initial encounter	ICD-10-CM	Diagnosis
T40.495D	Adverse effect of other synthetic narcotics, subsequent encounter	ICD-10-CM	Diagnosis
T40.495S	Adverse effect of other synthetic narcotics, sequela	ICD-10-CM	Diagnosis
T40.4X1A	Poisoning by other synthetic narcotics, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.4X1D	Poisoning by other synthetic narcotics, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis
T40.4X1S	Poisoning by other synthetic narcotics, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.4X2A	Poisoning by other synthetic narcotics, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.4X2D	Poisoning by other synthetic narcotics, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.4X2S	Poisoning by other synthetic narcotics, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.4X3A	Poisoning by other synthetic narcotics, assault, initial encounter	ICD-10-CM	Diagnosis
T40.4X3D	Poisoning by other synthetic narcotics, assault, subsequent encounter	ICD-10-CM	Diagnosis
T40.4X3S	Poisoning by other synthetic narcotics, assault, sequela	ICD-10-CM	Diagnosis
T40.4X4A	Poisoning by other synthetic narcotics, undetermined, initial encounter	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
T40.4X4D	Poisoning by other synthetic narcotics, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.4X4S	Poisoning by other synthetic narcotics, undetermined, sequela	ICD-10-CM	Diagnosis
T40.4X5A	Adverse effect of other synthetic narcotics, initial encounter	ICD-10-CM	Diagnosis
T40.4X5D	Adverse effect of other synthetic narcotics, subsequent encounter	ICD-10-CM	Diagnosis
T40.4X5S	Adverse effect of other synthetic narcotics, sequela	ICD-10-CM	Diagnosis
T40.601A	Poisoning by unspecified narcotics, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.601D	Poisoning by unspecified narcotics, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis
T40.601S	Poisoning by unspecified narcotics, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.602A	Poisoning by unspecified narcotics, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.602D	Poisoning by unspecified narcotics, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.602S	Poisoning by unspecified narcotics, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.603A	Poisoning by unspecified narcotics, assault, initial encounter	ICD-10-CM	Diagnosis
T40.603D	Poisoning by unspecified narcotics, assault, subsequent encounter	ICD-10-CM	Diagnosis
T40.603S	Poisoning by unspecified narcotics, assault, sequela	ICD-10-CM	Diagnosis
T40.604A	Poisoning by unspecified narcotics, undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.604D	Poisoning by unspecified narcotics, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.604S	Poisoning by unspecified narcotics, undetermined, sequela	ICD-10-CM	Diagnosis
T40.605A	Adverse effect of unspecified narcotics, initial encounter	ICD-10-CM	Diagnosis
T40.605D	Adverse effect of unspecified narcotics, subsequent encounter	ICD-10-CM	Diagnosis
T40.605S	Adverse effect of unspecified narcotics, sequela	ICD-10-CM	Diagnosis
T40.691A	Poisoning by other narcotics, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.691D	Poisoning by other narcotics, accidental (unintentional), subsequent encounter	ICD-10-CM	Diagnosis
T40.691S	Poisoning by other narcotics, accidental (unintentional), sequela	ICD-10-CM	Diagnosis
T40.692A	Poisoning by other narcotics, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.692D	Poisoning by other narcotics, intentional self-harm, subsequent encounter	ICD-10-CM	Diagnosis
T40.692S	Poisoning by other narcotics, intentional self-harm, sequela	ICD-10-CM	Diagnosis
T40.693A	Poisoning by other narcotics, assault, initial encounter	ICD-10-CM	Diagnosis
T40.693D	Poisoning by other narcotics, assault, subsequent encounter	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
T40.693S	Poisoning by other narcotics, assault, sequela	ICD-10-CM	Diagnosis
T40.694A	Poisoning by other narcotics, undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.694D	Poisoning by other narcotics, undetermined, subsequent encounter	ICD-10-CM	Diagnosis
T40.694S	Poisoning by other narcotics, undetermined, sequela	ICD-10-CM	Diagnosis
T40.695A	Adverse effect of other narcotics, initial encounter	ICD-10-CM	Diagnosis
T40.695D	Adverse effect of other narcotics, subsequent encounter	ICD-10-CM	Diagnosis
T40.695S	Adverse effect of other narcotics, sequela	ICD-10-CM	Diagnosis
T40.7X1A	Poisoning by cannabis (derivatives), accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.7X2A	Poisoning by cannabis (derivatives), intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.7X3A	Poisoning by cannabis (derivatives), assault, initial encounter	ICD-10-CM	Diagnosis
T40.7X4A	Poisoning by cannabis (derivatives), undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.7X5A	Adverse effect of cannabis (derivatives), initial encounter	ICD-10-CM	Diagnosis
T40.7X5S	Adverse effect of cannabis (derivatives), sequela	ICD-10-CM	Diagnosis
T40.8X1A	Poisoning by lysergide [LSD], accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.8X2A	Poisoning by lysergide [LSD], intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.8X3A	Poisoning by lysergide [LSD], assault, initial encounter	ICD-10-CM	Diagnosis
T40.8X4A	Poisoning by lysergide [LSD], undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.901A	Poisoning by unspecified psychodysleptics [hallucinogens], accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.902A	Poisoning by unspecified psychodysleptics [hallucinogens], intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.903A	Poisoning by unspecified psychodysleptics [hallucinogens], assault, initial encounter	ICD-10-CM	Diagnosis
T40.904A	Poisoning by unspecified psychodysleptics [hallucinogens], undetermined, initial encounter	ICD-10-CM	Diagnosis
T40.905A	Adverse effect of unspecified psychodysleptics [hallucinogens], initial encounter	ICD-10-CM	Diagnosis
T40.905S	Adverse effect of unspecified psychodysleptics [hallucinogens], sequela	ICD-10-CM	Diagnosis
T40.991A	Poisoning by other psychodysleptics [hallucinogens], accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T40.992A	Poisoning by other psychodysleptics [hallucinogens], intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T40.993A	Poisoning by other psychodysleptics [hallucinogens], assault, initial encounter	ICD-10-CM	Diagnosis
T40.994A	Poisoning by other psychodysleptics [hallucinogens], undetermined, initial encounter	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
T40.995A	Adverse effect of other psychodysleptics [hallucinogens], initial encounter	ICD-10-CM	Diagnosis
T40.995S	Adverse effect of other psychodysleptics [hallucinogens], sequela	ICD-10-CM	Diagnosis
T41.3X1A	Poisoning by local anesthetics, accidental (unintentional), initial encounter	ICD-10-CM	Diagnosis
T41.3X2A	Poisoning by local anesthetics, intentional self-harm, initial encounter	ICD-10-CM	Diagnosis
T41.3X3A	Poisoning by local anesthetics, assault, initial encounter	ICD-10-CM	Diagnosis
T41.3X4A	Poisoning by local anesthetics, undetermined, initial encounter	ICD-10-CM	Diagnosis
Z71.41	Alcohol abuse counseling and surveillance of alcoholic	ICD-10-CM	Diagnosis
Z71.42	Counseling for family member of alcoholic	ICD-10-CM	Diagnosis
Z71.51	Drug abuse counseling and surveillance of drug abuser	ICD-10-CM	Diagnosis
Z71.52	Counseling for family member of drug abuser	ICD-10-CM	Diagnosis
Z71.6	Tobacco abuse counseling	ICD-10-CM	Diagnosis
HZ81ZZZ	Medication Management for Substance Abuse Treatment, Methadone Maintenance	ICD-10-PCS	Procedure
HZ85ZZZ	Medication Management for Substance Abuse Treatment, Naloxone	ICD-10-PCS	Procedure
HZ86ZZZ	Medication Management for Substance Abuse Treatment, Clonidine	ICD-10-PCS	Procedure
HZ91ZZZ	Pharmacotherapy for Substance Abuse Treatment, Methadone Maintenance	ICD-10-PCS	Procedure
HZ95ZZZ	Pharmacotherapy for Substance Abuse Treatment, Naloxone	ICD-10-PCS	Procedure
HZ96ZZZ	Pharmacotherapy for Substance Abuse Treatment, Clonidine	ICD-10-PCS	Procedure
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program)	HCPCS	Procedure
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	HCPCS	Procedure
G2069	Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	HCPCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
G2070	Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	HCPCS	Procedure
G2071	Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	HCPCS	Procedure
G2072	Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	HCPCS	Procedure
G2078	Take home supply of methadone; up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	HCPCS	Procedure
G2079	Take home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	HCPCS	Procedure
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	HCPCS	Procedure
J0571	Buprenorphine, oral, 1 mg	HCPCS	Procedure
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	HCPCS	Procedure
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	HCPCS	Procedure
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	HCPCS	Procedure
J0575	Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine	HCPCS	Procedure
J0592	Injection, buprenorphine HCl, 0.1 mg	HCPCS	Procedure
J1230	Injection, methadone HCl, up to 10 mg	HCPCS	Procedure
S0109	Methadone, oral, 5 mg	HCPCS	Procedure
	Crohn's Disease		
K50.0	Crohn's disease of small intestine	ICD-10-CM	Diagnosis
K50.00	Crohn's disease of small intestine without complications	ICD-10-CM	Diagnosis
K50.01	Crohn's disease of small intestine with complications	ICD-10-CM	Diagnosis
K50.011	Crohn's disease of small intestine with rectal bleeding	ICD-10-CM	Diagnosis
K50.012	Crohn's disease of small intestine with intestinal obstruction	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
K50.013	Crohn's disease of small intestine with fistula	ICD-10-CM	Diagnosis
K50.014	Crohn's disease of small intestine with abscess	ICD-10-CM	Diagnosis
K50.018	Crohn's disease of small intestine with other complication	ICD-10-CM	Diagnosis
K50.019	Crohn's disease of small intestine with unspecified complications	ICD-10-CM	Diagnosis
K50.1	Crohn's disease of large intestine	ICD-10-CM	Diagnosis
K50.10	Crohn's disease of large intestine without complications	ICD-10-CM	Diagnosis
K50.11	Crohn's disease of large intestine with complications	ICD-10-CM	Diagnosis
K50.111	Crohn's disease of large intestine with rectal bleeding	ICD-10-CM	Diagnosis
K50.112	Crohn's disease of large intestine with intestinal obstruction	ICD-10-CM	Diagnosis
K50.113	Crohn's disease of large intestine with fistula	ICD-10-CM	Diagnosis
K50.114	Crohn's disease of large intestine with abscess	ICD-10-CM	Diagnosis
K50.118	Crohn's disease of large intestine with other complication	ICD-10-CM	Diagnosis
K50.119	Crohn's disease of large intestine with unspecified complications	ICD-10-CM	Diagnosis
K50.8	Crohn's disease of both small and large intestine	ICD-10-CM	Diagnosis
K50.80	Crohn's disease of both small and large intestine without complications	ICD-10-CM	Diagnosis
K50.81	Crohn's disease of both small and large intestine with complications	ICD-10-CM	Diagnosis
K50.811	Crohn's disease of both small and large intestine with rectal bleeding	ICD-10-CM	Diagnosis
K50.812	Crohn's disease of both small and large intestine with intestinal obstruction	ICD-10-CM	Diagnosis
K50.813	Crohn's disease of both small and large intestine with fistula	ICD-10-CM	Diagnosis
K50.814	Crohn's disease of both small and large intestine with abscess	ICD-10-CM	Diagnosis
K50.818	Crohn's disease of both small and large intestine with other complication	ICD-10-CM	Diagnosis
K50.819	Crohn's disease of both small and large intestine with unspecified complications	ICD-10-CM	Diagnosis
K50.9	Crohn's disease, unspecified	ICD-10-CM	Diagnosis
K50.90	Crohn's disease, unspecified, without complications	ICD-10-CM	Diagnosis
K50.91	Crohn's disease, unspecified, with complications	ICD-10-CM	Diagnosis
K50.911	Crohn's disease, unspecified, with rectal bleeding	ICD-10-CM	Diagnosis
K50.912	Crohn's disease, unspecified, with intestinal obstruction	ICD-10-CM	Diagnosis
K50.913	Crohn's disease, unspecified, with fistula	ICD-10-CM	Diagnosis
K50.914	Crohn's disease, unspecified, with abscess	ICD-10-CM	Diagnosis
K50.918	Crohn's disease, unspecified, with other complication	ICD-10-CM	Diagnosis
K50.919	Crohn's disease, unspecified, with unspecified complications	ICD-10-CM	Diagnosis
K50	Crohn's disease [regional enteritis]	ICD-10-CM	Diagnosis
555.0	Regional enteritis of small intestine	ICD-9-CM	Diagnosis
555.1	Regional enteritis of large intestine	ICD-9-CM	Diagnosis
555.2	Regional enteritis of small intestine with large intestine	ICD-9-CM	Diagnosis
555.9	Regional enteritis of unspecified site	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
	Rheumatoid Arthritis		
714.0	Rheumatoid arthritis	ICD-9-CM	Diagnosis
714.1	Felty's syndrome	ICD-9-CM	Diagnosis
714.2	Other rheumatoid arthritis with visceral or systemic involvement	ICD-9-CM	Diagnosis
714.30	Polyarticular juvenile rheumatoid arthritis, chronic or unspecified	ICD-9-CM	Diagnosis
714.31	Polyarticular juvenile rheumatoid arthritis, acute	ICD-9-CM	Diagnosis
714.32	Pauciarticular juvenile rheumatoid arthritis	ICD-9-CM	Diagnosis
714.33	Monoarticular juvenile rheumatoid arthritis	ICD-9-CM	Diagnosis
720.0	Ankylosing spondylitis	ICD-9-CM	Diagnosis
721.0	Cervical spondylosis without myelopathy	ICD-9-CM	Diagnosis
721.1	Cervical spondylosis with myelopathy	ICD-9-CM	Diagnosis
721.2	Thoracic spondylosis without myelopathy	ICD-9-CM	Diagnosis
721.3	Lumbosacral spondylosis without myelopathy	ICD-9-CM	Diagnosis
721.90	Spondylosis of unspecified site without mention of myelopathy	ICD-9-CM	Diagnosis
721.91	Spondylosis of unspecified site with myelopathy	ICD-9-CM	Diagnosis
M05.00	Felty's syndrome, unspecified site	ICD-10-CM	Diagnosis
M05.011	Felty's syndrome, right shoulder	ICD-10-CM	Diagnosis
M05.012	Felty's syndrome, left shoulder	ICD-10-CM	Diagnosis
M05.019	Felty's syndrome, unspecified shoulder	ICD-10-CM	Diagnosis
M05.021	Felty's syndrome, right elbow	ICD-10-CM	Diagnosis
M05.022	Felty's syndrome, left elbow	ICD-10-CM	Diagnosis
M05.029	Felty's syndrome, unspecified elbow	ICD-10-CM	Diagnosis
M05.031	Felty's syndrome, right wrist	ICD-10-CM	Diagnosis
M05.032	Felty's syndrome, left wrist	ICD-10-CM	Diagnosis
M05.039	Felty's syndrome, unspecified wrist	ICD-10-CM	Diagnosis
M05.041	Felty's syndrome, right hand	ICD-10-CM	Diagnosis
M05.042	Felty's syndrome, left hand	ICD-10-CM	Diagnosis
M05.049	Felty's syndrome, unspecified hand	ICD-10-CM	Diagnosis
M05.051	Felty's syndrome, right hip	ICD-10-CM	Diagnosis
M05.052	Felty's syndrome, left hip	ICD-10-CM	Diagnosis
M05.059	Felty's syndrome, unspecified hip	ICD-10-CM	Diagnosis
M05.061	Felty's syndrome, right knee	ICD-10-CM	Diagnosis
M05.062	Felty's syndrome, left knee	ICD-10-CM	Diagnosis
M05.069	Felty's syndrome, unspecified knee	ICD-10-CM	Diagnosis
M05.071	Felty's syndrome, right ankle and foot	ICD-10-CM	Diagnosis
M05.072	Felty's syndrome, left ankle and foot	ICD-10-CM	Diagnosis
M05.079	Felty's syndrome, unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.09	Felty's syndrome, multiple sites	ICD-10-CM	Diagnosis
M05.20	Rheumatoid vasculitis with rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M05.211	Rheumatoid vasculitis with rheumatoid arthritis of right shoulder	ICD-10-CM	Diagnosis
M05.212	Rheumatoid vasculitis with rheumatoid arthritis of left shoulder	ICD-10-CM	Diagnosis
M05.219	Rheumatoid vasculitis with rheumatoid arthritis of unspecified shoulder	ICD-10-CM	Diagnosis
M05.221	Rheumatoid vasculitis with rheumatoid arthritis of right elbow	ICD-10-CM	Diagnosis
M05.222	Rheumatoid vasculitis with rheumatoid arthritis of left elbow	ICD-10-CM	Diagnosis
M05.229	Rheumatoid vasculitis with rheumatoid arthritis of unspecified elbow	ICD-10-CM	Diagnosis
M05.231	Rheumatoid vasculitis with rheumatoid arthritis of right wrist	ICD-10-CM	Diagnosis
M05.232	Rheumatoid vasculitis with rheumatoid arthritis of left wrist	ICD-10-CM	Diagnosis
M05.239	Rheumatoid vasculitis with rheumatoid arthritis of unspecified wrist	ICD-10-CM	Diagnosis
M05.241	Rheumatoid vasculitis with rheumatoid arthritis of right hand	ICD-10-CM	Diagnosis
M05.242	Rheumatoid vasculitis with rheumatoid arthritis of left hand	ICD-10-CM	Diagnosis
M05.249	Rheumatoid vasculitis with rheumatoid arthritis of unspecified hand	ICD-10-CM	Diagnosis
M05.251	Rheumatoid vasculitis with rheumatoid arthritis of right hip	ICD-10-CM	Diagnosis
M05.252	Rheumatoid vasculitis with rheumatoid arthritis of left hip	ICD-10-CM	Diagnosis
M05.259	Rheumatoid vasculitis with rheumatoid arthritis of unspecified hip	ICD-10-CM	Diagnosis
M05.261	Rheumatoid vasculitis with rheumatoid arthritis of right knee	ICD-10-CM	Diagnosis
M05.262	Rheumatoid vasculitis with rheumatoid arthritis of left knee	ICD-10-CM	Diagnosis
M05.269	Rheumatoid vasculitis with rheumatoid arthritis of unspecified knee	ICD-10-CM	Diagnosis
M05.271	Rheumatoid vasculitis with rheumatoid arthritis of right ankle and foot	ICD-10-CM	Diagnosis
M05.272	Rheumatoid vasculitis with rheumatoid arthritis of left ankle and foot	ICD-10-CM	Diagnosis
M05.279	Rheumatoid vasculitis with rheumatoid arthritis of unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.29	Rheumatoid vasculitis with rheumatoid arthritis of multiple sites	ICD-10-CM	Diagnosis
M05.30	Rheumatoid heart disease with rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis
M05.311	Rheumatoid heart disease with rheumatoid arthritis of right shoulder	ICD-10-CM	Diagnosis
M05.312	Rheumatoid heart disease with rheumatoid arthritis of left shoulder	ICD-10-CM	Diagnosis
M05.319	Rheumatoid heart disease with rheumatoid arthritis of unspecified shoulder	ICD-10-CM	Diagnosis
M05.321	Rheumatoid heart disease with rheumatoid arthritis of right elbow	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M05.322	Rheumatoid heart disease with rheumatoid arthritis of left elbow	ICD-10-CM	Diagnosis
M05.329	Rheumatoid heart disease with rheumatoid arthritis of unspecified elbow	ICD-10-CM	Diagnosis
M05.331	Rheumatoid heart disease with rheumatoid arthritis of right wrist	ICD-10-CM	Diagnosis
M05.332	Rheumatoid heart disease with rheumatoid arthritis of left wrist	ICD-10-CM	Diagnosis
M05.339	Rheumatoid heart disease with rheumatoid arthritis of unspecified wrist	ICD-10-CM	Diagnosis
M05.341	Rheumatoid heart disease with rheumatoid arthritis of right hand	ICD-10-CM	Diagnosis
M05.342	Rheumatoid heart disease with rheumatoid arthritis of left hand	ICD-10-CM	Diagnosis
M05.349	Rheumatoid heart disease with rheumatoid arthritis of unspecified hand	ICD-10-CM	Diagnosis
M05.351	Rheumatoid heart disease with rheumatoid arthritis of right hip	ICD-10-CM	Diagnosis
M05.352	Rheumatoid heart disease with rheumatoid arthritis of left hip	ICD-10-CM	Diagnosis
M05.359	Rheumatoid heart disease with rheumatoid arthritis of unspecified hip	ICD-10-CM	Diagnosis
M05.361	Rheumatoid heart disease with rheumatoid arthritis of right knee	ICD-10-CM	Diagnosis
M05.362	Rheumatoid heart disease with rheumatoid arthritis of left knee	ICD-10-CM	Diagnosis
M05.369	Rheumatoid heart disease with rheumatoid arthritis of unspecified knee	ICD-10-CM	Diagnosis
M05.371	Rheumatoid heart disease with rheumatoid arthritis of right ankle and foot	ICD-10-CM	Diagnosis
M05.372	Rheumatoid heart disease with rheumatoid arthritis of left ankle and foot	ICD-10-CM	Diagnosis
M05.379	Rheumatoid heart disease with rheumatoid arthritis of unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.39	Rheumatoid heart disease with rheumatoid arthritis of multiple sites	ICD-10-CM	Diagnosis
M05.40	Rheumatoid myopathy with rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis
M05.411	Rheumatoid myopathy with rheumatoid arthritis of right shoulder	ICD-10-CM	Diagnosis
M05.412	Rheumatoid myopathy with rheumatoid arthritis of left shoulder	ICD-10-CM	Diagnosis
M05.419	Rheumatoid myopathy with rheumatoid arthritis of unspecified shoulder	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M05.421	Rheumatoid myopathy with rheumatoid arthritis of right elbow	ICD-10-CM	Diagnosis
M05.422	Rheumatoid myopathy with rheumatoid arthritis of left elbow	ICD-10-CM	Diagnosis
M05.429	Rheumatoid myopathy with rheumatoid arthritis of unspecified elbow	ICD-10-CM	Diagnosis
M05.431	Rheumatoid myopathy with rheumatoid arthritis of right wrist	ICD-10-CM	Diagnosis
M05.432	Rheumatoid myopathy with rheumatoid arthritis of left wrist	ICD-10-CM	Diagnosis
M05.439	Rheumatoid myopathy with rheumatoid arthritis of unspecified wrist	ICD-10-CM	Diagnosis
M05.441	Rheumatoid myopathy with rheumatoid arthritis of right hand	ICD-10-CM	Diagnosis
M05.442	Rheumatoid myopathy with rheumatoid arthritis of left hand	ICD-10-CM	Diagnosis
M05.449	Rheumatoid myopathy with rheumatoid arthritis of unspecified hand	ICD-10-CM	Diagnosis
M05.451	Rheumatoid myopathy with rheumatoid arthritis of right hip	ICD-10-CM	Diagnosis
M05.452	Rheumatoid myopathy with rheumatoid arthritis of left hip	ICD-10-CM	Diagnosis
M05.459	Rheumatoid myopathy with rheumatoid arthritis of unspecified hip	ICD-10-CM	Diagnosis
M05.461	Rheumatoid myopathy with rheumatoid arthritis of right knee	ICD-10-CM	Diagnosis
M05.462	Rheumatoid myopathy with rheumatoid arthritis of left knee	ICD-10-CM	Diagnosis
M05.469	Rheumatoid myopathy with rheumatoid arthritis of unspecified knee	ICD-10-CM	Diagnosis
M05.471	Rheumatoid myopathy with rheumatoid arthritis of right ankle and foot	ICD-10-CM	Diagnosis
M05.472	Rheumatoid myopathy with rheumatoid arthritis of left ankle and foot	ICD-10-CM	Diagnosis
M05.479	Rheumatoid myopathy with rheumatoid arthritis of unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.49	Rheumatoid myopathy with rheumatoid arthritis of multiple sites	ICD-10-CM	Diagnosis
M05.50	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis
M05.511	Rheumatoid polyneuropathy with rheumatoid arthritis of right shoulder	ICD-10-CM	Diagnosis
M05.512	Rheumatoid polyneuropathy with rheumatoid arthritis of left shoulder	ICD-10-CM	Diagnosis
M05.519	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified shoulder	ICD-10-CM	Diagnosis
M05.521	Rheumatoid polyneuropathy with rheumatoid arthritis of right elbow	ICD-10-CM	Diagnosis
M05.522	Rheumatoid polyneuropathy with rheumatoid arthritis of left elbow	ICD-10-CM	Diagnosis
M05.529	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified elbow	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
M05.531	Rheumatoid polyneuropathy with rheumatoid arthritis of right wrist	ICD-10-CM	Diagnosis
M05.532	Rheumatoid polyneuropathy with rheumatoid arthritis of left wrist	ICD-10-CM	Diagnosis
M05.539	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified wrist	ICD-10-CM	Diagnosis
M05.541	Rheumatoid polyneuropathy with rheumatoid arthritis of right hand	ICD-10-CM	Diagnosis
M05.542	Rheumatoid polyneuropathy with rheumatoid arthritis of left hand	ICD-10-CM	Diagnosis
M05.549	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hand	ICD-10-CM	Diagnosis
M05.551	Rheumatoid polyneuropathy with rheumatoid arthritis of right hip	ICD-10-CM	Diagnosis
M05.552	Rheumatoid polyneuropathy with rheumatoid arthritis of left hip	ICD-10-CM	Diagnosis
M05.559	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hip	ICD-10-CM	Diagnosis
M05.561	Rheumatoid polyneuropathy with rheumatoid arthritis of right knee	ICD-10-CM	Diagnosis
M05.562	Rheumatoid polyneuropathy with rheumatoid arthritis of left knee	ICD-10-CM	Diagnosis
M05.569	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified knee	ICD-10-CM	Diagnosis
M05.571	Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot	ICD-10-CM	Diagnosis
M05.572	Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot	ICD-10-CM	Diagnosis
M05.579	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.59	Rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites	ICD-10-CM	Diagnosis
M05.60	Rheumatoid arthritis of unspecified site with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.611	Rheumatoid arthritis of right shoulder with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.612	Rheumatoid arthritis of left shoulder with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.619	Rheumatoid arthritis of unspecified shoulder with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.621	Rheumatoid arthritis of right elbow with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.622	Rheumatoid arthritis of left elbow with involvement of other organs and systems	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
M05.629	Rheumatoid arthritis of unspecified elbow with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.631	Rheumatoid arthritis of right wrist with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.632	Rheumatoid arthritis of left wrist with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.639	Rheumatoid arthritis of unspecified wrist with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.641	Rheumatoid arthritis of right hand with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.642	Rheumatoid arthritis of left hand with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.649	Rheumatoid arthritis of unspecified hand with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.651	Rheumatoid arthritis of right hip with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.652	Rheumatoid arthritis of left hip with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.659	Rheumatoid arthritis of unspecified hip with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.661	Rheumatoid arthritis of right knee with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.662	Rheumatoid arthritis of left knee with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.669	Rheumatoid arthritis of unspecified knee with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.671	Rheumatoid arthritis of right ankle and foot with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.672	Rheumatoid arthritis of left ankle and foot with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.679	Rheumatoid arthritis of unspecified ankle and foot with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.69	Rheumatoid arthritis of multiple sites with involvement of other organs and systems	ICD-10-CM	Diagnosis
M05.70	Rheumatoid arthritis with rheumatoid factor of unspecified site without organ or systems involvement	ICD-10-CM	Diagnosis
M05.711	Rheumatoid arthritis with rheumatoid factor of right shoulder without organ or systems involvement	ICD-10-CM	Diagnosis
M05.712	Rheumatoid arthritis with rheumatoid factor of left shoulder without organ or systems involvement	ICD-10-CM	Diagnosis
M05.719	Rheumatoid arthritis with rheumatoid factor of unspecified shoulder without organ or systems involvement	ICD-10-CM	Diagnosis
M05.721	Rheumatoid arthritis with rheumatoid factor of right elbow without organ or systems involvement	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
M05.722	Rheumatoid arthritis with rheumatoid factor of left elbow without organ or systems involvement	ICD-10-CM	Diagnosis
M05.729	Rheumatoid arthritis with rheumatoid factor of unspecified elbow without organ or systems involvement	ICD-10-CM	Diagnosis
M05.731	Rheumatoid arthritis with rheumatoid factor of right wrist without organ or systems involvement	ICD-10-CM	Diagnosis
M05.732	Rheumatoid arthritis with rheumatoid factor of left wrist without organ or systems involvement	ICD-10-CM	Diagnosis
M05.739	Rheumatoid arthritis with rheumatoid factor of unspecified wrist without organ or systems involvement	ICD-10-CM	Diagnosis
M05.741	Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement	ICD-10-CM	Diagnosis
M05.742	Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement	ICD-10-CM	Diagnosis
M05.749	Rheumatoid arthritis with rheumatoid factor of unspecified hand without organ or systems involvement	ICD-10-CM	Diagnosis
M05.751	Rheumatoid arthritis with rheumatoid factor of right hip without organ or systems involvement	ICD-10-CM	Diagnosis
M05.752	Rheumatoid arthritis with rheumatoid factor of left hip without organ or systems involvement	ICD-10-CM	Diagnosis
M05.759	Rheumatoid arthritis with rheumatoid factor of unspecified hip without organ or systems involvement	ICD-10-CM	Diagnosis
M05.761	Rheumatoid arthritis with rheumatoid factor of right knee without organ or systems involvement	ICD-10-CM	Diagnosis
M05.762	Rheumatoid arthritis with rheumatoid factor of left knee without organ or systems involvement	ICD-10-CM	Diagnosis
M05.769	Rheumatoid arthritis with rheumatoid factor of unspecified knee without organ or systems involvement	ICD-10-CM	Diagnosis
M05.771	Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement	ICD-10-CM	Diagnosis
M05.772	Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement	ICD-10-CM	Diagnosis
M05.779	Rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot without organ or systems involvement	ICD-10-CM	Diagnosis
M05.79	Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement	ICD-10-CM	Diagnosis
M05.7A	Rheumatoid arthritis with rheumatoid factor of other specified site without organ or systems involvement	ICD-10-CM	Diagnosis
M05.80	Other rheumatoid arthritis with rheumatoid factor of unspecified site	ICD-10-CM	Diagnosis
M05.811	Other rheumatoid arthritis with rheumatoid factor of right shoulder	ICD-10-CM	Diagnosis
M05.812	Other rheumatoid arthritis with rheumatoid factor of left shoulder	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
M05.819	Other rheumatoid arthritis with rheumatoid factor of unspecified shoulder	ICD-10-CM	Diagnosis
M05.821	Other rheumatoid arthritis with rheumatoid factor of right elbow	ICD-10-CM	Diagnosis
M05.822	Other rheumatoid arthritis with rheumatoid factor of left elbow	ICD-10-CM	Diagnosis
M05.829	Other rheumatoid arthritis with rheumatoid factor of unspecified elbow	ICD-10-CM	Diagnosis
M05.831	Other rheumatoid arthritis with rheumatoid factor of right wrist	ICD-10-CM	Diagnosis
M05.832	Other rheumatoid arthritis with rheumatoid factor of left wrist	ICD-10-CM	Diagnosis
M05.839	Other rheumatoid arthritis with rheumatoid factor of unspecified wrist	ICD-10-CM	Diagnosis
M05.841	Other rheumatoid arthritis with rheumatoid factor of right hand	ICD-10-CM	Diagnosis
M05.842	Other rheumatoid arthritis with rheumatoid factor of left hand	ICD-10-CM	Diagnosis
M05.849	Other rheumatoid arthritis with rheumatoid factor of unspecified hand	ICD-10-CM	Diagnosis
M05.851	Other rheumatoid arthritis with rheumatoid factor of right hip	ICD-10-CM	Diagnosis
M05.852	Other rheumatoid arthritis with rheumatoid factor of left hip	ICD-10-CM	Diagnosis
M05.859	Other rheumatoid arthritis with rheumatoid factor of unspecified hip	ICD-10-CM	Diagnosis
M05.861	Other rheumatoid arthritis with rheumatoid factor of right knee	ICD-10-CM	Diagnosis
M05.862	Other rheumatoid arthritis with rheumatoid factor of left knee	ICD-10-CM	Diagnosis
M05.869	Other rheumatoid arthritis with rheumatoid factor of unspecified knee	ICD-10-CM	Diagnosis
M05.871	Other rheumatoid arthritis with rheumatoid factor of right ankle and foot	ICD-10-CM	Diagnosis
M05.872	Other rheumatoid arthritis with rheumatoid factor of left ankle and foot	ICD-10-CM	Diagnosis
M05.879	Other rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot	ICD-10-CM	Diagnosis
M05.89	Other rheumatoid arthritis with rheumatoid factor of multiple sites	ICD-10-CM	Diagnosis
M05.8A	Other rheumatoid arthritis with rheumatoid factor of other specified site	ICD-10-CM	Diagnosis
M05.9	Rheumatoid arthritis with rheumatoid factor, unspecified	ICD-10-CM	Diagnosis
M06.00	Rheumatoid arthritis without rheumatoid factor, unspecified site	ICD-10-CM	Diagnosis
M06.011	Rheumatoid arthritis without rheumatoid factor, right shoulder	ICD-10-CM	Diagnosis
M06.012	Rheumatoid arthritis without rheumatoid factor, left shoulder	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
M06.019	Rheumatoid arthritis without rheumatoid factor, unspecified shoulder	ICD-10-CM	Diagnosis
M06.021	Rheumatoid arthritis without rheumatoid factor, right elbow	ICD-10-CM	Diagnosis
M06.022	Rheumatoid arthritis without rheumatoid factor, left elbow	ICD-10-CM	Diagnosis
M06.029	Rheumatoid arthritis without rheumatoid factor, unspecified elbow	ICD-10-CM	Diagnosis
M06.031	Rheumatoid arthritis without rheumatoid factor, right wrist	ICD-10-CM	Diagnosis
M06.032	Rheumatoid arthritis without rheumatoid factor, left wrist	ICD-10-CM	Diagnosis
M06.039	Rheumatoid arthritis without rheumatoid factor, unspecified wrist	ICD-10-CM	Diagnosis
M06.041	Rheumatoid arthritis without rheumatoid factor, right hand	ICD-10-CM	Diagnosis
M06.042	Rheumatoid arthritis without rheumatoid factor, left hand	ICD-10-CM	Diagnosis
M06.049	Rheumatoid arthritis without rheumatoid factor, unspecified hand	ICD-10-CM	Diagnosis
M06.051	Rheumatoid arthritis without rheumatoid factor, right hip	ICD-10-CM	Diagnosis
M06.052	Rheumatoid arthritis without rheumatoid factor, left hip	ICD-10-CM	Diagnosis
M06.059	Rheumatoid arthritis without rheumatoid factor, unspecified hip	ICD-10-CM	Diagnosis
M06.061	Rheumatoid arthritis without rheumatoid factor, right knee	ICD-10-CM	Diagnosis
M06.062	Rheumatoid arthritis without rheumatoid factor, left knee	ICD-10-CM	Diagnosis
M06.069	Rheumatoid arthritis without rheumatoid factor, unspecified knee	ICD-10-CM	Diagnosis
M06.071	Rheumatoid arthritis without rheumatoid factor, right ankle and foot	ICD-10-CM	Diagnosis
M06.072	Rheumatoid arthritis without rheumatoid factor, left ankle and foot	ICD-10-CM	Diagnosis
M06.079	Rheumatoid arthritis without rheumatoid factor, unspecified ankle and foot	ICD-10-CM	Diagnosis
M06.08	Rheumatoid arthritis without rheumatoid factor, vertebrae	ICD-10-CM	Diagnosis
M06.09	Rheumatoid arthritis without rheumatoid factor, multiple sites	ICD-10-CM	Diagnosis
M06.0A	Rheumatoid arthritis without rheumatoid factor, other specified site	ICD-10-CM	Diagnosis
M06.1	Adult-onset Still's disease	ICD-10-CM	Diagnosis
M06.20	Rheumatoid bursitis, unspecified site	ICD-10-CM	Diagnosis
M06.211	Rheumatoid bursitis, right shoulder	ICD-10-CM	Diagnosis
M06.212	Rheumatoid bursitis, left shoulder	ICD-10-CM	Diagnosis
M06.219	Rheumatoid bursitis, unspecified shoulder	ICD-10-CM	Diagnosis
M06.221	Rheumatoid bursitis, right elbow	ICD-10-CM	Diagnosis
M06.222	Rheumatoid bursitis, left elbow	ICD-10-CM	Diagnosis
M06.229	Rheumatoid bursitis, unspecified elbow	ICD-10-CM	Diagnosis
M06.231	Rheumatoid bursitis, right wrist	ICD-10-CM	Diagnosis
M06.232	Rheumatoid bursitis, left wrist	ICD-10-CM	Diagnosis
M06.239	Rheumatoid bursitis, unspecified wrist	ICD-10-CM	Diagnosis
M06.241	Rheumatoid bursitis, right hand	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
M06.242	Rheumatoid bursitis, left hand	ICD-10-CM	Diagnosis
M06.249	Rheumatoid bursitis, unspecified hand	ICD-10-CM	Diagnosis
M06.251	Rheumatoid bursitis, right hip	ICD-10-CM	Diagnosis
M06.252	Rheumatoid bursitis, left hip	ICD-10-CM	Diagnosis
M06.259	Rheumatoid bursitis, unspecified hip	ICD-10-CM	Diagnosis
M06.261	Rheumatoid bursitis, right knee	ICD-10-CM	Diagnosis
M06.262	Rheumatoid bursitis, left knee	ICD-10-CM	Diagnosis
M06.269	Rheumatoid bursitis, unspecified knee	ICD-10-CM	Diagnosis
M06.271	Rheumatoid bursitis, right ankle and foot	ICD-10-CM	Diagnosis
M06.272	Rheumatoid bursitis, left ankle and foot	ICD-10-CM	Diagnosis
M06.279	Rheumatoid bursitis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M06.28	Rheumatoid bursitis, vertebrae	ICD-10-CM	Diagnosis
M06.29	Rheumatoid bursitis, multiple sites	ICD-10-CM	Diagnosis
M06.30	Rheumatoid nodule, unspecified site	ICD-10-CM	Diagnosis
M06.311	Rheumatoid nodule, right shoulder	ICD-10-CM	Diagnosis
M06.312	Rheumatoid nodule, left shoulder	ICD-10-CM	Diagnosis
M06.319	Rheumatoid nodule, unspecified shoulder	ICD-10-CM	Diagnosis
M06.321	Rheumatoid nodule, right elbow	ICD-10-CM	Diagnosis
M06.322	Rheumatoid nodule, left elbow	ICD-10-CM	Diagnosis
M06.329	Rheumatoid nodule, unspecified elbow	ICD-10-CM	Diagnosis
M06.331	Rheumatoid nodule, right wrist	ICD-10-CM	Diagnosis
M06.332	Rheumatoid nodule, left wrist	ICD-10-CM	Diagnosis
M06.339	Rheumatoid nodule, unspecified wrist	ICD-10-CM	Diagnosis
M06.341	Rheumatoid nodule, right hand	ICD-10-CM	Diagnosis
M06.342	Rheumatoid nodule, left hand	ICD-10-CM	Diagnosis
M06.349	Rheumatoid nodule, unspecified hand	ICD-10-CM	Diagnosis
M06.351	Rheumatoid nodule, right hip	ICD-10-CM	Diagnosis
M06.352	Rheumatoid nodule, left hip	ICD-10-CM	Diagnosis
M06.359	Rheumatoid nodule, unspecified hip	ICD-10-CM	Diagnosis
M06.361	Rheumatoid nodule, right knee	ICD-10-CM	Diagnosis
M06.362	Rheumatoid nodule, left knee	ICD-10-CM	Diagnosis
M06.369	Rheumatoid nodule, unspecified knee	ICD-10-CM	Diagnosis
M06.371	Rheumatoid nodule, right ankle and foot	ICD-10-CM	Diagnosis
M06.372	Rheumatoid nodule, left ankle and foot	ICD-10-CM	Diagnosis
M06.379	Rheumatoid nodule, unspecified ankle and foot	ICD-10-CM	Diagnosis
M06.38	Rheumatoid nodule, vertebrae	ICD-10-CM	Diagnosis
M06.39	Rheumatoid nodule, multiple sites	ICD-10-CM	Diagnosis
M06.80	Other specified rheumatoid arthritis, unspecified site	ICD-10-CM	Diagnosis
M06.811	Other specified rheumatoid arthritis, right shoulder	ICD-10-CM	Diagnosis
M06.812	Other specified rheumatoid arthritis, left shoulder	ICD-10-CM	Diagnosis
M06.819	Other specified rheumatoid arthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M06.821	Other specified rheumatoid arthritis, right elbow	ICD-10-CM	Diagnosis
M06.822	Other specified rheumatoid arthritis, left elbow	ICD-10-CM	Diagnosis
M06.829	Other specified rheumatoid arthritis, unspecified elbow	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M06.831	Other specified rheumatoid arthritis, right wrist	ICD-10-CM	Diagnosis
M06.832	Other specified rheumatoid arthritis, left wrist	ICD-10-CM	Diagnosis
M06.839	Other specified rheumatoid arthritis, unspecified wrist	ICD-10-CM	Diagnosis
M06.841	Other specified rheumatoid arthritis, right hand	ICD-10-CM	Diagnosis
M06.842	Other specified rheumatoid arthritis, left hand	ICD-10-CM	Diagnosis
M06.849	Other specified rheumatoid arthritis, unspecified hand	ICD-10-CM	Diagnosis
M06.851	Other specified rheumatoid arthritis, right hip	ICD-10-CM	Diagnosis
M06.852	Other specified rheumatoid arthritis, left hip	ICD-10-CM	Diagnosis
M06.859	Other specified rheumatoid arthritis, unspecified hip	ICD-10-CM	Diagnosis
M06.861	Other specified rheumatoid arthritis, right knee	ICD-10-CM	Diagnosis
M06.862	Other specified rheumatoid arthritis, left knee	ICD-10-CM	Diagnosis
M06.869	Other specified rheumatoid arthritis, unspecified knee	ICD-10-CM	Diagnosis
M06.871	Other specified rheumatoid arthritis, right ankle and foot	ICD-10-CM	Diagnosis
M06.872	Other specified rheumatoid arthritis, left ankle and foot	ICD-10-CM	Diagnosis
M06.879	Other specified rheumatoid arthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M06.88	Other specified rheumatoid arthritis, vertebrae	ICD-10-CM	Diagnosis
M06.89	Other specified rheumatoid arthritis, multiple sites	ICD-10-CM	Diagnosis
M06.8A	Other specified rheumatoid arthritis, other specified site	ICD-10-CM	Diagnosis
M06.9	Rheumatoid arthritis, unspecified	ICD-10-CM	Diagnosis
M08.00	Unspecified juvenile rheumatoid arthritis of unspecified site	ICD-10-CM	Diagnosis
M08.011	Unspecified juvenile rheumatoid arthritis, right shoulder	ICD-10-CM	Diagnosis
M08.012	Unspecified juvenile rheumatoid arthritis, left shoulder	ICD-10-CM	Diagnosis
M08.019	Unspecified juvenile rheumatoid arthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M08.021	Unspecified juvenile rheumatoid arthritis, right elbow	ICD-10-CM	Diagnosis
M08.022	Unspecified juvenile rheumatoid arthritis, left elbow	ICD-10-CM	Diagnosis
M08.029	Unspecified juvenile rheumatoid arthritis, unspecified elbow	ICD-10-CM	Diagnosis
M08.031	Unspecified juvenile rheumatoid arthritis, right wrist	ICD-10-CM	Diagnosis
M08.032	Unspecified juvenile rheumatoid arthritis, left wrist	ICD-10-CM	Diagnosis
M08.039	Unspecified juvenile rheumatoid arthritis, unspecified wrist	ICD-10-CM	Diagnosis
M08.041	Unspecified juvenile rheumatoid arthritis, right hand	ICD-10-CM	Diagnosis
M08.042	Unspecified juvenile rheumatoid arthritis, left hand	ICD-10-CM	Diagnosis
M08.049	Unspecified juvenile rheumatoid arthritis, unspecified hand	ICD-10-CM	Diagnosis
M08.051	Unspecified juvenile rheumatoid arthritis, right hip	ICD-10-CM	Diagnosis
M08.052	Unspecified juvenile rheumatoid arthritis, left hip	ICD-10-CM	Diagnosis
M08.059	Unspecified juvenile rheumatoid arthritis, unspecified hip	ICD-10-CM	Diagnosis
M08.061	Unspecified juvenile rheumatoid arthritis, right knee	ICD-10-CM	Diagnosis
M08.062	Unspecified juvenile rheumatoid arthritis, left knee	ICD-10-CM	Diagnosis
M08.069	Unspecified juvenile rheumatoid arthritis, unspecified knee	ICD-10-CM	Diagnosis
M08.071	Unspecified juvenile rheumatoid arthritis, right ankle and foot	ICD-10-CM	Diagnosis
M08.072	Unspecified juvenile rheumatoid arthritis, left ankle and foot	ICD-10-CM	Diagnosis
M08.079	Unspecified juvenile rheumatoid arthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M08.08	Unspecified juvenile rheumatoid arthritis, vertebrae	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M08.09	Unspecified juvenile rheumatoid arthritis, multiple sites	ICD-10-CM	Diagnosis
M08.0A	Unspecified juvenile rheumatoid arthritis, other specified site	ICD-10-CM	Diagnosis
M08.1	Juvenile ankylosing spondylitis	ICD-10-CM	Diagnosis
M08.20	Juvenile rheumatoid arthritis with systemic onset, unspecified site	ICD-10-CM	Diagnosis
M08.211	Juvenile rheumatoid arthritis with systemic onset, right shoulder	ICD-10-CM	Diagnosis
M08.212	Juvenile rheumatoid arthritis with systemic onset, left shoulder	ICD-10-CM	Diagnosis
M08.219	Juvenile rheumatoid arthritis with systemic onset, unspecified shoulder	ICD-10-CM	Diagnosis
M08.221	Juvenile rheumatoid arthritis with systemic onset, right elbow	ICD-10-CM	Diagnosis
M08.222	Juvenile rheumatoid arthritis with systemic onset, left elbow	ICD-10-CM	Diagnosis
M08.229	Juvenile rheumatoid arthritis with systemic onset, unspecified elbow	ICD-10-CM	Diagnosis
M08.231	Juvenile rheumatoid arthritis with systemic onset, right wrist	ICD-10-CM	Diagnosis
M08.232	Juvenile rheumatoid arthritis with systemic onset, left wrist	ICD-10-CM	Diagnosis
M08.239	Juvenile rheumatoid arthritis with systemic onset, unspecified wrist	ICD-10-CM	Diagnosis
M08.241	Juvenile rheumatoid arthritis with systemic onset, right hand	ICD-10-CM	Diagnosis
M08.242	Juvenile rheumatoid arthritis with systemic onset, left hand	ICD-10-CM	Diagnosis
M08.249	Juvenile rheumatoid arthritis with systemic onset, unspecified hand	ICD-10-CM	Diagnosis
M08.251	Juvenile rheumatoid arthritis with systemic onset, right hip	ICD-10-CM	Diagnosis
M08.252	Juvenile rheumatoid arthritis with systemic onset, left hip	ICD-10-CM	Diagnosis
M08.259	Juvenile rheumatoid arthritis with systemic onset, unspecified hip	ICD-10-CM	Diagnosis
M08.261	Juvenile rheumatoid arthritis with systemic onset, right knee	ICD-10-CM	Diagnosis
M08.262	Juvenile rheumatoid arthritis with systemic onset, left knee	ICD-10-CM	Diagnosis
M08.269	Juvenile rheumatoid arthritis with systemic onset, unspecified knee	ICD-10-CM	Diagnosis
M08.271	Juvenile rheumatoid arthritis with systemic onset, right ankle and foot	ICD-10-CM	Diagnosis
M08.272	Juvenile rheumatoid arthritis with systemic onset, left ankle and foot	ICD-10-CM	Diagnosis
M08.279	Juvenile rheumatoid arthritis with systemic onset, unspecified ankle and foot	ICD-10-CM	Diagnosis
M08.28	Juvenile rheumatoid arthritis with systemic onset, vertebrae	ICD-10-CM	Diagnosis
M08.29	Juvenile rheumatoid arthritis with systemic onset, multiple sites	ICD-10-CM	Diagnosis
M08.2A	Juvenile rheumatoid arthritis with systemic onset, other specified site	ICD-10-CM	Diagnosis
M08.3	Juvenile rheumatoid polyarthritis (seronegative)	ICD-10-CM	Diagnosis
M08.40	Pauciarticular juvenile rheumatoid arthritis, unspecified site	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M08.411	Pauciarticular juvenile rheumatoid arthritis, right shoulder	ICD-10-CM	Diagnosis
M08.412	Pauciarticular juvenile rheumatoid arthritis, left shoulder	ICD-10-CM	Diagnosis
M08.419	Pauciarticular juvenile rheumatoid arthritis, unspecified shoulder	ICD-10-CM	Diagnosis
M08.421	Pauciarticular juvenile rheumatoid arthritis, right elbow	ICD-10-CM	Diagnosis
M08.422	Pauciarticular juvenile rheumatoid arthritis, left elbow	ICD-10-CM	Diagnosis
M08.429	Pauciarticular juvenile rheumatoid arthritis, unspecified elbow	ICD-10-CM	Diagnosis
M08.431	Pauciarticular juvenile rheumatoid arthritis, right wrist	ICD-10-CM	Diagnosis
M08.432	Pauciarticular juvenile rheumatoid arthritis, left wrist	ICD-10-CM	Diagnosis
M08.439	Pauciarticular juvenile rheumatoid arthritis, unspecified wrist	ICD-10-CM	Diagnosis
M08.441	Pauciarticular juvenile rheumatoid arthritis, right hand	ICD-10-CM	Diagnosis
M08.442	Pauciarticular juvenile rheumatoid arthritis, left hand	ICD-10-CM	Diagnosis
M08.449	Pauciarticular juvenile rheumatoid arthritis, unspecified hand	ICD-10-CM	Diagnosis
M08.451	Pauciarticular juvenile rheumatoid arthritis, right hip	ICD-10-CM	Diagnosis
M08.452	Pauciarticular juvenile rheumatoid arthritis, left hip	ICD-10-CM	Diagnosis
M08.459	Pauciarticular juvenile rheumatoid arthritis, unspecified hip	ICD-10-CM	Diagnosis
M08.461	Pauciarticular juvenile rheumatoid arthritis, right knee	ICD-10-CM	Diagnosis
M08.462	Pauciarticular juvenile rheumatoid arthritis, left knee	ICD-10-CM	Diagnosis
M08.469	Pauciarticular juvenile rheumatoid arthritis, unspecified knee	ICD-10-CM	Diagnosis
M08.471	Pauciarticular juvenile rheumatoid arthritis, right ankle and foot	ICD-10-CM	Diagnosis
M08.472	Pauciarticular juvenile rheumatoid arthritis, left ankle and foot	ICD-10-CM	Diagnosis
M08.479	Pauciarticular juvenile rheumatoid arthritis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M08.48	Pauciarticular juvenile rheumatoid arthritis, vertebrae	ICD-10-CM	Diagnosis
M08.4A	Pauciarticular juvenile rheumatoid arthritis, other specified site	ICD-10-CM	Diagnosis
M45.0	Ankylosing spondylitis of multiple sites in spine	ICD-10-CM	Diagnosis
M45.1	Ankylosing spondylitis of occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M45.2	Ankylosing spondylitis of cervical region	ICD-10-CM	Diagnosis
M45.3	Ankylosing spondylitis of cervicothoracic region	ICD-10-CM	Diagnosis
M45.4	Ankylosing spondylitis of thoracic region	ICD-10-CM	Diagnosis
M45.5	Ankylosing spondylitis of thoracolumbar region	ICD-10-CM	Diagnosis
M45.6	Ankylosing spondylitis lumbar region	ICD-10-CM	Diagnosis
M45.7	Ankylosing spondylitis of lumbosacral region	ICD-10-CM	Diagnosis
M45.8	Ankylosing spondylitis sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M45.9	Ankylosing spondylitis of unspecified sites in spine	ICD-10-CM	Diagnosis
M47.011	Anterior spinal artery compression syndromes, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.012	Anterior spinal artery compression syndromes, cervical region	ICD-10-CM	Diagnosis
M47.013	Anterior spinal artery compression syndromes, cervicothoracic region	ICD-10-CM	Diagnosis
M47.014	Anterior spinal artery compression syndromes, thoracic region	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M47.015	Anterior spinal artery compression syndromes, thoracolumbar region	ICD-10-CM	Diagnosis
M47.016	Anterior spinal artery compression syndromes, lumbar region	ICD-10-CM	Diagnosis
M47.019	Anterior spinal artery compression syndromes, site unspecified	ICD-10-CM	Diagnosis
M47.021	Vertebral artery compression syndromes, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.022	Vertebral artery compression syndromes, cervical region	ICD-10-CM	Diagnosis
M47.029	Vertebral artery compression syndromes, site unspecified	ICD-10-CM	Diagnosis
M47.10	Other spondylosis with myelopathy, site unspecified	ICD-10-CM	Diagnosis
M47.11	Other spondylosis with myelopathy, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.12	Other spondylosis with myelopathy, cervical region	ICD-10-CM	Diagnosis
M47.13	Other spondylosis with myelopathy, cervicothoracic region	ICD-10-CM	Diagnosis
M47.20	Other spondylosis with radiculopathy, site unspecified	ICD-10-CM	Diagnosis
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.22	Other spondylosis with radiculopathy, cervical region	ICD-10-CM	Diagnosis
M47.23	Other spondylosis with radiculopathy, cervicothoracic region	ICD-10-CM	Diagnosis
M47.24	Other spondylosis with radiculopathy, thoracic region	ICD-10-CM	Diagnosis
M47.25	Other spondylosis with radiculopathy, thoracolumbar region	ICD-10-CM	Diagnosis
M47.26	Other spondylosis with radiculopathy, lumbar region	ICD-10-CM	Diagnosis
M47.27	Other spondylosis with radiculopathy, lumbosacral region	ICD-10-CM	Diagnosis
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region	ICD-10-CM	Diagnosis
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region	ICD-10-CM	Diagnosis
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region	ICD-10-CM	Diagnosis
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region	ICD-10-CM	Diagnosis
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region	ICD-10-CM	Diagnosis
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region	ICD-10-CM	Diagnosis
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M47.819	Spondylosis without myelopathy or radiculopathy, site unspecified	ICD-10-CM	Diagnosis
M47.891	Other spondylosis, occipito-atlanto-axial region	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M47.892	Other spondylosis, cervical region	ICD-10-CM	Diagnosis
M47.893	Other spondylosis, cervicothoracic region	ICD-10-CM	Diagnosis
M47.894	Other spondylosis, thoracic region	ICD-10-CM	Diagnosis
M47.895	Other spondylosis, thoracolumbar region	ICD-10-CM	Diagnosis
M47.896	Other spondylosis, lumbar region	ICD-10-CM	Diagnosis
M47.897	Other spondylosis, lumbosacral region	ICD-10-CM	Diagnosis
M47.898	Other spondylosis, sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M47.899	Other spondylosis, site unspecified	ICD-10-CM	Diagnosis
M47.9	Spondylosis, unspecified	ICD-10-CM	Diagnosis
M48.8X1	Other specified spondylopathies, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M48.8X2	Other specified spondylopathies, cervical region	ICD-10-CM	Diagnosis
M48.8X3	Other specified spondylopathies, cervicothoracic region	ICD-10-CM	Diagnosis
M48.8X4	Other specified spondylopathies, thoracic region	ICD-10-CM	Diagnosis
M48.8X5	Other specified spondylopathies, thoracolumbar region	ICD-10-CM	Diagnosis
M48.8X6	Other specified spondylopathies, lumbar region	ICD-10-CM	Diagnosis
M48.8X7	Other specified spondylopathies, lumbosacral region	ICD-10-CM	Diagnosis
M48.8X8	Other specified spondylopathies, sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M48.8X9	Other specified spondylopathies, site unspecified	ICD-10-CM	Diagnosis
	Chronic Autoimmune Hepatitis		
070.42	Hepatitis delta without mention of active hepatitis B disease with hepatic coma	ICD-9-CM	Diagnosis
070.44	Chronic hepatitis C with hepatic coma	ICD-9-CM	Diagnosis
070.52	Hepatitis delta without mention of active hepatitis B disease or hepatic coma	ICD-9-CM	Diagnosis
070.54	Chronic hepatitis C without mention of hepatic coma	ICD-9-CM	Diagnosis
B18.0	Chronic viral hepatitis B with delta-agent	ICD-10-CM	Diagnosis
B18.1	Chronic viral hepatitis B without delta-agent	ICD-10-CM	Diagnosis
B18.2	Chronic viral hepatitis C	ICD-10-CM	Diagnosis
B18.8	Other chronic viral hepatitis	ICD-10-CM	Diagnosis
B18.9	Chronic viral hepatitis, unspecified	ICD-10-CM	Diagnosis
V02.6	Carrier or suspected carrier of viral hepatitis	ICD-10-CM	Diagnosis
V02.60	Unspecified viral hepatitis carrier	ICD-10-CM	Diagnosis
V02.61	Hepatitis B carrier	ICD-10-CM	Diagnosis
V02.62	Hepatitis C carrier	ICD-10-CM	Diagnosis
V02.69	Other viral hepatitis carrier	ICD-10-CM	Diagnosis
Z22.50	Carrier of unspecified viral hepatitis	ICD-10-CM	Diagnosis
Z22.51	Carrier of viral hepatitis B	ICD-10-CM	Diagnosis
Z22.52	Carrier of viral hepatitis C	ICD-10-CM	Diagnosis
Z22.59	Carrier of other viral hepatitis	ICD-10-CM	Diagnosis
	Systemic Lupus Erythematosus		
L93	Lupus erythematosus	ICD-9-CM	Diagnosis
L93.0	Discoid lupus erythematosus	ICD-10-CM	Diagnosis
L93.1	Subacute cutaneous lupus erythematosus	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
L93.2	Other local lupus erythematosus	ICD-10-CM	Diagnosis
695.4	Lupus erythematosus	ICD-10-CM	Diagnosis
	Chemotherapy		
96400	Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia	CPT-4	Procedure
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	CPT-4	Procedure
96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic	CPT-4	Procedure
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	CPT-4	Procedure
96406	Chemotherapy administration; intralesional, more than 7 lesions	CPT-4	Procedure
96408	Chemotherapy administration, intravenous; push technique	CPT-4	Procedure
96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug	CPT-4	Procedure
96410	Chemotherapy administration, intravenous; infusion technique, up to one hour	CPT-4	Procedure
96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)	CPT-4	Procedure
96412	Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)	CPT-4	Procedure
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	CPT-4	Procedure
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	CPT-4	Procedure
96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)	CPT-4	Procedure
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	CPT-4	Procedure
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)	CPT-4	Procedure
96420	Chemotherapy administration, intra-arterial; push technique	CPT-4	Procedure
96422	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour	CPT-4	Procedure

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Code	Description	Code Type	Code Category
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)	CPT-4	Procedure
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	CPT-4	Procedure
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	CPT-4	Procedure
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	CPT-4	Procedure
96446	Chemotherapy administration into the peritoneal cavity via indwelling port or catheter	CPT-4	Procedure
96450	Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture	CPT-4	Procedure
96500	Chemotherapy Injection, Intravenous, Single Premixed Agent,	CPT-4	Procedure
96501	Chemotherapy Injection, Intravenous, Single Premixed Agent,	CPT-4	Procedure
96504	Chemotherapy Injection, Intravenous, Multiple Premixed Agents,	CPT-4	Procedure
96505	Chemotherapy Injection, Intravenous, Multiple Premixed Agents,	CPT-4	Procedure
96508	Chemotherapy Injection, Intravenous, Complex, Using One Or	CPT-4	Procedure
96509	Chemotherapy Injection, Intravenous, Complex, Using One Or	CPT-4	Procedure
96510	Chemotherapy Injection, Intravenous, Complex, Using One Or	CPT-4	Procedure
96511	Chemotherapy Injection, Intravenous, Complex, Using One Or	CPT-4	Procedure
96512	Chemotherapy Injection, Intravenous, Complex, Using One Or	CPT-4	Procedure
96524	Chemotherapy Injection, Complex, Administered By Physician,	CPT-4	Procedure
96526	Chemotherapy Injection, Complex, Administered By Physician,	CPT-4	Procedure
96535	Chemotherapy Injection, Complex, Requiring Thoracentesis	CPT-4	Procedure
96538	Chemotherapy Injection, Requiring Lumbar Puncture, Administered	CPT-4	Procedure
96540	Chemotherapy Injection, Intrathecal Via Reservoir, Single Or	CPT-4	Procedure
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	CPT-4	Procedure
96549	Unlisted chemotherapy procedure	CPT-4	Procedure
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B	CPT-4	Procedure
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	CPT-4	Procedure
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	CPT-4	Procedure
3E00X05	Introduction of Other Antineoplastic into Skin and Mucous Membranes, External Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
3E00X0M	Introduction of Antineoplastic, Monoclonal Antibody, into Skin and Mucous Membranes, External Approach	ICD-10-PCS	Procedure
3E01305	Introduction of Other Antineoplastic into Subcutaneous Tissue, Percutaneous Approach	ICD-10-PCS	Procedure
3E0130M	Introduction of Antineoplastic, Monoclonal Antibody, into Subcutaneous Tissue, Percutaneous Approach	ICD-10-PCS	Procedure
3E02305	Introduction of Other Antineoplastic into Muscle, Percutaneous Approach	ICD-10-PCS	Procedure
3E0230M	Introduction of Antineoplastic, Monoclonal Antibody, into Muscle, Percutaneous Approach	ICD-10-PCS	Procedure
3E03005	Introduction of Other Antineoplastic into Peripheral Vein, Open Approach	ICD-10-PCS	Procedure
3E0300M	Introduction of Antineoplastic, Monoclonal Antibody, into Peripheral Vein, Open Approach	ICD-10-PCS	Procedure
3E0300P	Introduction of Clofarabine into Peripheral Vein, Open Approach	ICD-10-PCS	Procedure
3E03305	Introduction of Other Antineoplastic into Peripheral Vein, Percutaneous Approach	ICD-10-PCS	Procedure
3E0330M	Introduction of Antineoplastic, Monoclonal Antibody, into Peripheral Vein, Percutaneous Approach	ICD-10-PCS	Procedure
3E0330P	Introduction of Clofarabine into Peripheral Vein, Percutaneous Approach	ICD-10-PCS	Procedure
3E04005	Introduction of Other Antineoplastic into Central Vein, Open Approach	ICD-10-PCS	Procedure
3E0400M	Introduction of Antineoplastic, Monoclonal Antibody, into Central Vein, Open Approach	ICD-10-PCS	Procedure
3E0400P	Introduction of Clofarabine into Central Vein, Open Approach	ICD-10-PCS	Procedure
3E04305	Introduction of Other Antineoplastic into Central Vein, Percutaneous Approach	ICD-10-PCS	Procedure
3E0430M	Introduction of Antineoplastic, Monoclonal Antibody, into Central Vein, Percutaneous Approach	ICD-10-PCS	Procedure
3E0430P	Introduction of Clofarabine into Central Vein, Percutaneous Approach	ICD-10-PCS	Procedure
3E05005	Introduction of Other Antineoplastic into Peripheral Artery, Open Approach	ICD-10-PCS	Procedure
3E0500M	Introduction of Antineoplastic, Monoclonal Antibody, into Peripheral Artery, Open Approach	ICD-10-PCS	Procedure
3E0500P	Introduction of Clofarabine into Peripheral Artery, Open Approach	ICD-10-PCS	Procedure
3E05305	Introduction of Other Antineoplastic into Peripheral Artery, Percutaneous Approach	ICD-10-PCS	Procedure
3E0530M	Introduction of Antineoplastic, Monoclonal Antibody, into Peripheral Artery, Percutaneous Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
3E0530P	Introduction of Clofarabine into Peripheral Artery, Percutaneous Approach	ICD-10-PCS	Procedure
3E06005	Introduction of Other Antineoplastic into Central Artery, Open Approach	ICD-10-PCS	Procedure
3E0600M	Introduction of Antineoplastic, Monoclonal Antibody, into Central Artery, Open Approach	ICD-10-PCS	Procedure
3E0600P	Introduction of Clofarabine into Central Artery, Open Approach	ICD-10-PCS	Procedure
3E06305	Introduction of Other Antineoplastic into Central Artery, Percutaneous Approach	ICD-10-PCS	Procedure
3E0630M	Introduction of Antineoplastic, Monoclonal Antibody, into Central Artery, Percutaneous Approach	ICD-10-PCS	Procedure
3E0630P	Introduction of Clofarabine into Central Artery, Percutaneous Approach	ICD-10-PCS	Procedure
3E09305	Introduction of Other Antineoplastic into Nose, Percutaneous Approach	ICD-10-PCS	Procedure
3E0930M	Introduction of Antineoplastic, Monoclonal Antibody, into Nose, Percutaneous Approach	ICD-10-PCS	Procedure
3E09705	Introduction of Other Antineoplastic into Nose, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0970M	Introduction of Antineoplastic, Monoclonal Antibody, into Nose, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E09X05	Introduction of Other Antineoplastic into Nose, External Approach	ICD-10-PCS	Procedure
3E09X0M	Introduction of Antineoplastic, Monoclonal Antibody, into Nose, External Approach	ICD-10-PCS	Procedure
3E0A305	Introduction of Other Antineoplastic into Bone Marrow, Percutaneous Approach	ICD-10-PCS	Procedure
3E0A30M	Introduction of Antineoplastic, Monoclonal Antibody, into Bone Marrow, Percutaneous Approach	ICD-10-PCS	Procedure
3E0B305	Introduction of Other Antineoplastic into Ear, Percutaneous Approach	ICD-10-PCS	Procedure
3E0B30M	Introduction of Antineoplastic, Monoclonal Antibody, into Ear, Percutaneous Approach	ICD-10-PCS	Procedure
3E0B705	Introduction of Other Antineoplastic into Ear, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0B70M	Introduction of Antineoplastic, Monoclonal Antibody, into Ear, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0BX05	Introduction of Other Antineoplastic into Ear, External Approach	ICD-10-PCS	Procedure
3E0BX0M	Introduction of Antineoplastic, Monoclonal Antibody, into Ear, External Approach	ICD-10-PCS	Procedure
3E0C305	Introduction of Other Antineoplastic into Eye, Percutaneous Approach	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
3E0C30M	Introduction of Antineoplastic, Monoclonal Antibody, into Eye, Percutaneous Approach	ICD-10-PCS	Procedure
3E0C705	Introduction of Other Antineoplastic into Eye, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0C70M	Introduction of Antineoplastic, Monoclonal Antibody, into Eye, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0CX05	Introduction of Other Antineoplastic into Eye, External Approach	ICD-10-PCS	Procedure
3E0CX0M	Introduction of Antineoplastic, Monoclonal Antibody, into Eye, External Approach	ICD-10-PCS	Procedure
3E0D305	Introduction of Other Antineoplastic into Mouth and Pharynx, Percutaneous Approach	ICD-10-PCS	Procedure
3E0D30M	Introduction of Antineoplastic, Monoclonal Antibody, into Mouth and Pharynx, Percutaneous Approach	ICD-10-PCS	Procedure
3E0D705	Introduction of Other Antineoplastic into Mouth and Pharynx, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0D70M	Introduction of Antineoplastic, Monoclonal Antibody, into Mouth and Pharynx, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0DX05	Introduction of Other Antineoplastic into Mouth and Pharynx, External Approach	ICD-10-PCS	Procedure
3E0DX0M	Introduction of Antineoplastic, Monoclonal Antibody, into Mouth and Pharynx, External Approach	ICD-10-PCS	Procedure
3E0E305	Introduction of Other Antineoplastic into Products of Conception, Percutaneous Approach	ICD-10-PCS	Procedure
3E0E30M	Introduction of Antineoplastic, Monoclonal Antibody, into Products of Conception, Percutaneous Approach	ICD-10-PCS	Procedure
3E0E705	Introduction of Other Antineoplastic into Products of Conception, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0E70M	Introduction of Antineoplastic, Monoclonal Antibody, into Products of Conception, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0E805	Introduction of Other Antineoplastic into Products of Conception, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0E80M	Introduction of Antineoplastic, Monoclonal Antibody, into Products of Conception, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0F305	Introduction of Other Antineoplastic into Respiratory Tract, Percutaneous Approach	ICD-10-PCS	Procedure
3E0F30M	Introduction of Antineoplastic, Monoclonal Antibody, into Respiratory Tract, Percutaneous Approach	ICD-10-PCS	Procedure
3E0F705	Introduction of Other Antineoplastic into Respiratory Tract, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0F70M	Introduction of Antineoplastic, Monoclonal Antibody, into Respiratory Tract, Via Natural or Artificial Opening	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
3E0F805	Introduction of Other Antineoplastic into Respiratory Tract, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0F80M	Introduction of Antineoplastic, Monoclonal Antibody, into Respiratory Tract, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0G305	Introduction of Other Antineoplastic into Upper GI, Percutaneous Approach	ICD-10-PCS	Procedure
3E0G30M	Introduction of Antineoplastic, Monoclonal Antibody, into Upper GI, Percutaneous Approach	ICD-10-PCS	Procedure
3E0G705	Introduction of Other Antineoplastic into Upper GI, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0G70M	Introduction of Antineoplastic, Monoclonal Antibody, into Upper GI, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0G805	Introduction of Other Antineoplastic into Upper GI, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0G80M	Introduction of Antineoplastic, Monoclonal Antibody, into Upper GI, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0H305	Introduction of Other Antineoplastic into Lower GI, Percutaneous Approach	ICD-10-PCS	Procedure
3E0H30M	Introduction of Antineoplastic, Monoclonal Antibody, into Lower GI, Percutaneous Approach	ICD-10-PCS	Procedure
3E0H705	Introduction of Other Antineoplastic into Lower GI, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0H70M	Introduction of Antineoplastic, Monoclonal Antibody, into Lower GI, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0H805	Introduction of Other Antineoplastic into Lower GI, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0H80M	Introduction of Antineoplastic, Monoclonal Antibody, into Lower GI, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0J305	Introduction of Other Antineoplastic into Biliary and Pancreatic Tract, Percutaneous Approach	ICD-10-PCS	Procedure
3E0J30M	Introduction of Antineoplastic, Monoclonal Antibody, into Biliary and Pancreatic Tract, Percutaneous Approach	ICD-10-PCS	Procedure
3E0J705	Introduction of Other Antineoplastic into Biliary and Pancreatic Tract, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0J70M	Introduction of Antineoplastic, Monoclonal Antibody, into Biliary and Pancreatic Tract, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0J805	Introduction of Other Antineoplastic into Biliary and Pancreatic Tract, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0J80M	Introduction of Antineoplastic, Monoclonal Antibody, into Biliary and Pancreatic Tract, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0K305	Introduction of Other Antineoplastic into Genitourinary Tract, Percutaneous Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
3E0K30M	Introduction of Antineoplastic, Monoclonal Antibody, into Genitourinary Tract, Percutaneous Approach	ICD-10-PCS	Procedure
3E0K705	Introduction of Other Antineoplastic into Genitourinary Tract, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0K70M	Introduction of Antineoplastic, Monoclonal Antibody, into Genitourinary Tract, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0K805	Introduction of Other Antineoplastic into Genitourinary Tract, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0K80M	Introduction of Antineoplastic, Monoclonal Antibody, into Genitourinary Tract, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0L305	Introduction of Other Antineoplastic into Pleural Cavity, Percutaneous Approach	ICD-10-PCS	Procedure
3E0L30M	Introduction of Antineoplastic, Monoclonal Antibody, into Pleural Cavity, Percutaneous Approach	ICD-10-PCS	Procedure
3E0L705	Introduction of Other Antineoplastic into Pleural Cavity, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0L70M	Introduction of Antineoplastic, Monoclonal Antibody, into Pleural Cavity, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0M305	Introduction of Other Antineoplastic into Peritoneal Cavity, Percutaneous Approach	ICD-10-PCS	Procedure
3E0M30M	Introduction of Antineoplastic, Monoclonal Antibody, into Peritoneal Cavity, Percutaneous Approach	ICD-10-PCS	Procedure
3E0M705	Introduction of Other Antineoplastic into Peritoneal Cavity, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0M70M	Introduction of Antineoplastic, Monoclonal Antibody, into Peritoneal Cavity, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0N305	Introduction of Other Antineoplastic into Male Reproductive, Percutaneous Approach	ICD-10-PCS	Procedure
3E0N30M	Introduction of Antineoplastic, Monoclonal Antibody, into Male Reproductive, Percutaneous Approach	ICD-10-PCS	Procedure
3E0N705	Introduction of Other Antineoplastic into Male Reproductive, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0N70M	Introduction of Antineoplastic, Monoclonal Antibody, into Male Reproductive, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0N805	Introduction of Other Antineoplastic into Male Reproductive, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0N80M	Introduction of Antineoplastic, Monoclonal Antibody, into Male Reproductive, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0P305	Introduction of Other Antineoplastic into Female Reproductive, Percutaneous Approach	ICD-10-PCS	Procedure
3E0P30M	Introduction of Antineoplastic, Monoclonal Antibody, into Female Reproductive, Percutaneous Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
3E0P705	Introduction of Other Antineoplastic into Female Reproductive, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0P70M	Introduction of Antineoplastic, Monoclonal Antibody, into Female Reproductive, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0P805	Introduction of Other Antineoplastic into Female Reproductive, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0P80M	Introduction of Antineoplastic, Monoclonal Antibody, into Female Reproductive, Via Natural or Artificial Opening Endoscopic	ICD-10-PCS	Procedure
3E0Q005	Introduction of Other Antineoplastic into Cranial Cavity and Brain, Open Approach	ICD-10-PCS	Procedure
3E0Q00M	Introduction of Antineoplastic, Monoclonal Antibody, into Cranial Cavity and Brain, Open Approach	ICD-10-PCS	Procedure
3E0Q305	Introduction of Other Antineoplastic into Cranial Cavity and Brain, Percutaneous Approach	ICD-10-PCS	Procedure
3E0Q30M	Introduction of Antineoplastic, Monoclonal Antibody, into Cranial Cavity and Brain, Percutaneous Approach	ICD-10-PCS	Procedure
3E0Q705	Introduction of Other Antineoplastic into Cranial Cavity and Brain, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0Q70M	Introduction of Antineoplastic, Monoclonal Antibody, into Cranial Cavity and Brain, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0R305	Introduction of Other Antineoplastic into Spinal Canal, Percutaneous Approach	ICD-10-PCS	Procedure
3E0R30M	Introduction of Antineoplastic, Monoclonal Antibody, into Spinal Canal, Percutaneous Approach	ICD-10-PCS	Procedure
3E0S305	Introduction of Other Antineoplastic into Epidural Space, Percutaneous Approach	ICD-10-PCS	Procedure
3E0S30M	Introduction of Antineoplastic, Monoclonal Antibody, into Epidural Space, Percutaneous Approach	ICD-10-PCS	Procedure
3E0U305	Introduction of Other Antineoplastic into Joints, Percutaneous Approach	ICD-10-PCS	Procedure
3E0U30M	Introduction of Antineoplastic, Monoclonal Antibody, into Joints, Percutaneous Approach	ICD-10-PCS	Procedure
3E0V305	Introduction of Other Antineoplastic into Bones, Percutaneous Approach	ICD-10-PCS	Procedure
3E0V30M	Introduction of Antineoplastic, Monoclonal Antibody, into Bones, Percutaneous Approach	ICD-10-PCS	Procedure
3E0W305	Introduction of Other Antineoplastic into Lymphatics, Percutaneous Approach	ICD-10-PCS	Procedure
3E0W30M	Introduction of Antineoplastic, Monoclonal Antibody, into Lymphatics, Percutaneous Approach	ICD-10-PCS	Procedure
3E0Y305	Introduction of Other Antineoplastic into Pericardial Cavity, Percutaneous Approach	ICD-10-PCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
3E0Y30M	Introduction of Antineoplastic, Monoclonal Antibody, into Pericardial Cavity, Percutaneous Approach	ICD-10-PCS	Procedure
3E0Y705	Introduction of Other Antineoplastic into Pericardial Cavity, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
3E0Y70M	Introduction of Antineoplastic, Monoclonal Antibody, into Pericardial Cavity, Via Natural or Artificial Opening	ICD-10-PCS	Procedure
4180F	Adjuvant chemotherapy referred, prescribed, or previously received for Stage III colon cancer (ONC)	CPT-2	Procedure
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	HCPCS	Procedure
C1084	Denileukin diftitox, 300 mcg, ontak iv	HCPCS	Procedure
C1086	Temozolomide, 5 mg, temodar	HCPCS	Procedure
C1166	Injection, cytarabine liposome, per 10 mg	HCPCS	Procedure
C1167	Injection, epirubicin HCl, 2 mg	HCPCS	Procedure
C1178	Injection, busulfan, per 6 mg	HCPCS	Procedure
C8953	Chemotherapy administration, intravenous; push technique	HCPCS	Procedure
C8954	Chemotherapy administration, intravenous; infusion technique, up to one hour	HCPCS	Procedure
C8955	Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)	HCPCS	Procedure
C9004	Injection, gemtuzumab ozogamicin, per 5 mg	HCPCS	Procedure
C9012	Injection, arsenic trioxide, per 1 mg/kg	HCPCS	Procedure
C9017	Lomustine, 10 mg	HCPCS	Procedure
C9021	Injection, obinutuzumab, 10 mg	HCPCS	Procedure
C9024	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	HCPCS	Procedure
C9042	Injection, bendamustine HCl (Belrapzo), 1 mg	HCPCS	Procedure
C9044	Injection, cemiplimab-rwlc, 1 mg	HCPCS	Procedure
C9045	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	HCPCS	Procedure
C9049	Injection, tagraxofusp-erzs, 10 mcg	HCPCS	Procedure
C9050	Injection, emapalumab-lzsg, 1 mg	HCPCS	Procedure
C9110	Injection, alemtuzumab, per 10 mg/ ml	HCPCS	Procedure
C9127	Injection, paclitaxel protein-bound particles, per 1 mg	HCPCS	Procedure
C9129	Injection, clofarabine, per 1 mg	HCPCS	Procedure
C9205	Injection, oxaliplatin, per 5 mg	HCPCS	Procedure
C9207	Injection, bortezomib, per 3.5 mg	HCPCS	Procedure
C9213	Injection, pemetrexed, per 10 mg	HCPCS	Procedure
C9214	Injection, bevacizumab, per 10 mg	HCPCS	Procedure
C9215	Injection, cetuximab, per 10 mg	HCPCS	Procedure
C9218	Injection, azacitidine, per 1 mg	HCPCS	Procedure
C9231	Injection, decitabine, per 1 mg	HCPCS	Procedure
C9235	Injection, panitumumab, 10 mg	HCPCS	Procedure
C9239	Injection, temsirolimus, 1 mg	HCPCS	Procedure
C9240	Injection, ixabepilone, 1 mg	HCPCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
C9243	Injection, bendamustine hcl, 1 mg	HCPCS	Procedure
C9253	Injection, temozolomide, 1mg	HCPCS	Procedure
C9259	Injection, pralatrexate, 1 mg	HCPCS	Procedure
C9260	Injection, ofatumumab, 10 mg	HCPCS	Procedure
C9262	Fludarabine phosphate, oral, 1 mg	HCPCS	Procedure
C9265	Injection, romidepsin, 1 mg	HCPCS	Procedure
C9276	Injection, cabazitaxel, 1 mg	HCPCS	Procedure
C9280	Injection, eribulin mesylate, 1 mg	HCPCS	Procedure
C9284	Injection, ipilimumab, 1 mg	HCPCS	Procedure
C9287	Injection, brentuximab vedotin, 1 mg	HCPCS	Procedure
C9289	Injection, asparaginase Erwinia chrysanthemi, 1,000 IU	HCPCS	Procedure
C9292	Injection, pertuzumab, 10 mg	HCPCS	Procedure
C9295	Injection, carfilzomib, 1 mg	HCPCS	Procedure
C9297	Injection, omacetaxine mepesuccinate, 0.01 mg	HCPCS	Procedure
C9414	Etoposide; oral, 50 mg, brand name	HCPCS	Procedure
C9415	Doxorubicin HCl, 10 mg, brand name	HCPCS	Procedure
C9417	Bleomycin sulfate, 15 units, brand name	HCPCS	Procedure
C9418	Cisplatin, powder or solution, per 10 mg, brand name	HCPCS	Procedure
C9419	Injection, cladribine, per 1 mg, brand name	HCPCS	Procedure
C9420	Cyclophosphamide, 100 mg, brand name	HCPCS	Procedure
C9421	Cyclophosphamide, lyophilized, 100 mg, brand name	HCPCS	Procedure
C9422	Cytarabine, 100 mg, brand name	HCPCS	Procedure
C9423	Dacarbazine, 100 mg, brand name	HCPCS	Procedure
C9424	Daunorubicin, 10 mg	HCPCS	Procedure
C9425	Etoposide, 10 mg, brand name	HCPCS	Procedure
C9426	Floxuridine, 500 mg, brand name	HCPCS	Procedure
C9427	Ifosfamide, 1 gm, brand name	HCPCS	Procedure
C9429	Idarubicin HCl, 5 mg, brand name	HCPCS	Procedure
C9431	Paclitaxel, 30 mg, brand name	HCPCS	Procedure
C9432	Mitomycin, 5 mg, brand name	HCPCS	Procedure
C9433	Thiotepa, 15 mg, brand name	HCPCS	Procedure
C9437	Carmustine, brand name, 100 mg	HCPCS	Procedure
C9440	Vinorelbine tartrate, brand name, per 10 mg	HCPCS	Procedure
C9474	Injection, irinotecan liposome, 1 mg	HCPCS	Procedure
G0355	Chemotherapy administration, subcutaneous or intramuscular nonhormonal antineoplastic	HCPCS	Procedure
G0359	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug	HCPCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
G0498	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion	HCPCS	Procedure
G3001	Administration and supply of tositumomab, 450 mg	HCPCS	Procedure
G8372	Chemotherapy documented as received or prescribed for Stage III colon cancer patients	HCPCS	Procedure
G8373	Chemotherapy plan documented prior to chemotherapy administration	HCPCS	Procedure
G8927	Adjuvant chemotherapy referred, prescribed or previously received for AJCC stage III, colon cancer	HCPCS	Procedure
G9829	Breast adjuvant chemotherapy administered	HCPCS	Procedure
G9835	Trastuzumab administered within 12 months of diagnosis	HCPCS	Procedure
J0202	Injection, alemtuzumab, 1 mg	HCPCS	Procedure
J0207	Injection, amifostine, 500 mg	HCPCS	Procedure
J0594	Injection, busulfan, 1 mg	HCPCS	Procedure
J0894	Injection, decitabine, 1 mg	HCPCS	Procedure
J7527	Everolimus, oral, 0.25 mg	HCPCS	Procedure
J8510	Busulfan, oral, 2 mg	HCPCS	Procedure
J8515	Cabergoline, oral, 0.25 mg	HCPCS	Procedure
J8520	Capecitabine, oral, 150 mg	HCPCS	Procedure
J8521	Capecitabine, oral, 500 mg	HCPCS	Procedure
J8530	Cyclophosphamide, oral, 25 mg	HCPCS	Procedure
J8560	Etoposide, oral, 50 mg	HCPCS	Procedure
J8561	Everolimus, oral, 0.25 mg	HCPCS	Procedure
J8562	Fludarabine phosphate, oral, 10 mg	HCPCS	Procedure
J8565	Gefitinib, oral, 250 mg	HCPCS	Procedure
J8600	Melphalan, oral, 2 mg	HCPCS	Procedure
J8610	Methotrexate, oral, 2.5 mg	HCPCS	Procedure
J8700	Temozolomide, oral, 5 mg	HCPCS	Procedure
J8705	Topotecan, oral, 0.25 mg	HCPCS	Procedure
J8999	Prescription drug, oral, chemotherapeutic, NOS	HCPCS	Procedure
J9000	Injection, doxorubicin HCl, 10 mg	HCPCS	Procedure
J9001	Injection, doxorubicin HCl, all lipid formulations, 10 mg	HCPCS	Procedure
J9002	Injection, doxorubicin hydrochloride, liposomal, Doxil, 10 mg	HCPCS	Procedure
J9010	Injection, alemtuzumab, 10 mg	HCPCS	Procedure
J9015	Injection, aldesleukin, per single use vial	HCPCS	Procedure
J9017	Injection, arsenic trioxide, 1 mg	HCPCS	Procedure
J9019	Injection, asparaginase (Erwinaze), 1,000 IU	HCPCS	Procedure
J9020	Injection, asparaginase, not otherwise specified, 10,000 units	HCPCS	Procedure
J9021	Injection, asparaginase, recombinant, (Rylaze), 0.1 mg	HCPCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
J9022	Injection, atezolizumab, 10 mg	HCPCS	Procedure
J9023	Injection, avelumab, 10 mg	HCPCS	Procedure
J9025	Injection, azacitidine, 1 mg	HCPCS	Procedure
J9027	Injection, clofarabine, 1 mg	HCPCS	Procedure
J9032	Injection, belinostat, 10 mg	HCPCS	Procedure
J9033	Injection, bendamustine HCl (Treanda), 1 mg	HCPCS	Procedure
J9034	Injection, bendamustine HCl (Bendeka), 1 mg	HCPCS	Procedure
J9035	Injection, bevacizumab, 10 mg	HCPCS	Procedure
J9036	Injection, bendamustine HCl, (Belrapzo/bendamustine), 1 mg	HCPCS	Procedure
J9037	Injection, belantamab mafodotin-blmf, 0.5 mg	HCPCS	Procedure
J9039	Injection, blinatumomab, 1 mcg	HCPCS	Procedure
J9040	Injection, bleomycin sulfate, 15 units	HCPCS	Procedure
J9041	Injection, bortezomib, 0.1 mg	HCPCS	Procedure
J9042	Injection, brentuximab vedotin, 1 mg	HCPCS	Procedure
J9043	Injection, cabazitaxel, 1 mg	HCPCS	Procedure
J9045	Injection, carboplatin, 50 mg	HCPCS	Procedure
J9046	Injection, bortezomib (Dr. Reddy's), not therapeutically equivalent to J9041, 0.1 mg	HCPCS	Procedure
J9047	Injection, carfilzomib, 1 mg	HCPCS	Procedure
J9048	Injection, bortezomib (Fresenius Kabi), not therapeutically equivalent to J9041, 0.1 mg	HCPCS	Procedure
J9049	Injection, bortezomib (Hospira), not therapeutically equivalent to J9041, 0.1 mg	HCPCS	Procedure
J9050	Injection, carmustine, 100 mg	HCPCS	Procedure
J9055	Injection, cetuximab, 10 mg	HCPCS	Procedure
J9057	Injection, copanlisib, 1 mg	HCPCS	Procedure
J9060	Injection, cisplatin, powder or solution, 10 mg	HCPCS	Procedure
J9061	Injection, amivantamab-vmjw, 2 mg	HCPCS	Procedure
J9062	Cisplatin, 50 mg	HCPCS	Procedure
J9065	Injection, cladribine, per 1 mg	HCPCS	Procedure
J9070	Cyclophosphamide, 100 mg	HCPCS	Procedure
J9071	Injection, cyclophosphamide, (AuroMedics), 5 mg	HCPCS	Procedure
J9080	Cyclophosphamide, 200 mg	HCPCS	Procedure
J9090	Cyclophosphamide, 500 mg	HCPCS	Procedure
J9091	Cyclophosphamide, 1 g	HCPCS	Procedure
J9092	Cyclophosphamide, 2 g	HCPCS	Procedure
J9093	Cyclophosphamide, lyophilized, 100 mg	HCPCS	Procedure
J9094	Cyclophosphamide, lyophilized, 200 mg	HCPCS	Procedure
J9095	Cyclophosphamide, lyophilized, 500 mg	HCPCS	Procedure
J9096	Cyclophosphamide, lyophilized, 1 g	HCPCS	Procedure
J9097	Cyclophosphamide, lyophilized, 2 g	HCPCS	Procedure
J9098	Injection, cytarabine liposome, 10 mg	HCPCS	Procedure
J9100	Injection, cytarabine, 100 mg	HCPCS	Procedure
J9110	Injection, cytarabine, 500 mg	HCPCS	Procedure

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Code	Description	Code Type	Code Category
J9118	Injection, calaspargase pegol-mknl, 10 units	HCPCS	Procedure
J9119	Injection, cemiplimab-rwlc, 1 mg	HCPCS	Procedure
J9120	Injection, dactinomycin, 0.5 mg	HCPCS	Procedure
J9130	Dacarbazine, 100 mg	HCPCS	Procedure
J9140	Dacarbazine, 200 mg	HCPCS	Procedure
J9144	Injection, daratumumab, 10 mg and hyaluronidase-fihj	HCPCS	Procedure
J9145	Injection, daratumumab, 10 mg	HCPCS	Procedure
J9150	Injection, daunorubicin, 10 mg	HCPCS	Procedure
J9151	Injection, daunorubicin citrate, liposomal formulation, 10 mg	HCPCS	Procedure
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	HCPCS	Procedure
J9155	Injection, degarelix, 1 mg	HCPCS	Procedure
J9160	Injection, denileukin diftitox, 300 mcg	HCPCS	Procedure
J9165	Injection, diethylstilbestrol diphosphate, 250 mg	HCPCS	Procedure
J9170	Injection, docetaxel, 20 mg	HCPCS	Procedure
J9171	Injection, docetaxel, 1 mg	HCPCS	Procedure
J9173	Injection, durvalumab, 10 mg	HCPCS	Procedure
J9175	Injection, Elliotts' B solution, 1 ml	HCPCS	Procedure
J9176	Injection, elotuzumab, 1 mg	HCPCS	Procedure
J9177	Injection, enfortumab vedotin-ejfv, 0.25 mg	HCPCS	Procedure
J9178	Injection, epirubicin HCl, 2 mg	HCPCS	Procedure
J9179	Injection, eribulin mesylate, 0.1 mg	HCPCS	Procedure
J9180	Epirubicin HCl, 50 mg	HCPCS	Procedure
J9181	Injection, etoposide, 10 mg	HCPCS	Procedure
J9182	Etoposide, 100 mg	HCPCS	Procedure
J9185	Injection, fludarabine phosphate, 50 mg	HCPCS	Procedure
J9190	Injection, fluorouracil, 500 mg	HCPCS	Procedure
J9198	Injection, gemcitabine HCl, (Infugem), 100 mg	HCPCS	Procedure
J9200	Injection, floxuridine, 500 mg	HCPCS	Procedure
J9201	Injection, gemcitabine HCl, not otherwise specified, 200 mg	HCPCS	Procedure
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	HCPCS	Procedure
J9204	Injection, mogamulizumab-kpkc, 1 mg	HCPCS	Procedure
J9205	Injection, irinotecan liposome, 1 mg	HCPCS	Procedure
J9206	Injection, irinotecan, 20 mg	HCPCS	Procedure
J9207	Injection, ixabepilone, 1 mg	HCPCS	Procedure
J9208	Injection, ifosfamide, 1 g	HCPCS	Procedure
J9209	Injection, mesna, 200 mg	HCPCS	Procedure
J9210	Injection, emapalumab-lzsg, 1 mg	HCPCS	Procedure
J9211	Injection, idarubicin HCl, 5 mg	HCPCS	Procedure
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	HCPCS	Procedure
J9218	Leuprolide acetate, per 1 mg	HCPCS	Procedure
J9219	Leuprolide acetate implant, 65 mg	HCPCS	Procedure
J9223	Injection, lurbinectedin, 0.1 mg	HCPCS	Procedure
J9227	Injection, isatuximab-irfc, 10 mg	HCPCS	Procedure

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Code	Description	Code Type	Code Category
J9228	Injection, ipilimumab, 1 mg	HCPCS	Procedure
J9229	Injection, inotuzumab ozogamicin, 0.1 mg	HCPCS	Procedure
J9230	Injection, mechlorethamine HCl, (nitrogen mustard), 10 mg	HCPCS	Procedure
J9245	Injection, melphalan HCl, not otherwise specified, 50 mg	HCPCS	Procedure
J9246	Injection, melphalan (Evomela), 1 mg	HCPCS	Procedure
J9247	Injection, melphalan flufenamide, 1 mg	HCPCS	Procedure
J9250	Methotrexate sodium, 5 mg	HCPCS	Procedure
J9260	Methotrexate sodium, 50 mg	HCPCS	Procedure
J9261	Injection, nelarabine, 50 mg	HCPCS	Procedure
J9262	Injection, omacetaxine mepesuccinate, 0.01 mg	HCPCS	Procedure
J9263	Injection, oxaliplatin, 0.5 mg	HCPCS	Procedure
J9264	Injection, paclitaxel protein-bound particles, 1 mg	HCPCS	Procedure
J9265	Injection, paclitaxel, 30 mg	HCPCS	Procedure
J9266	Injection, pegaspargase, per single dose vial	HCPCS	Procedure
J9267	Injection, paclitaxel, 1 mg	HCPCS	Procedure
J9268	Injection, pentostatin, 10 mg	HCPCS	Procedure
J9269	Injection, tagraxofusp-erzs, 10 mcg	HCPCS	Procedure
J9270	Injection, plicamycin, 2.5 mg	HCPCS	Procedure
J9271	Injection, pembrolizumab, 1 mg	HCPCS	Procedure
J9272	Injection, dostarlimab-gxly, 10 mg	HCPCS	Procedure
J9273	Injection, tisotumab vedotin-tftv, 1 mg	HCPCS	Procedure
J9274	Injection, tebentafusp-tebn, 1 mcg	HCPCS	Procedure
J9280	Injection, mitomycin, 5 mg	HCPCS	Procedure
J9285	Injection, olaratumab, 10 mg	HCPCS	Procedure
J9290	Mitomycin, 20 mg	HCPCS	Procedure
J9291	Mitomycin, 40 mg	HCPCS	Procedure
J9293	Injection, mitoxantrone HCl, per 5 mg	HCPCS	Procedure
J9295	Injection, necitumumab, 1 mg	HCPCS	Procedure
J9298	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg	HCPCS	Procedure
J9299	Injection, nivolumab, 1 mg	HCPCS	Procedure
J9300	Injection, gemtuzumab ozogamicin, 5 mg	HCPCS	Procedure
J9301	Injection, obinutuzumab, 10 mg	HCPCS	Procedure
J9302	Injection, ofatumumab, 10 mg	HCPCS	Procedure
J9303	Injection, panitumumab, 10 mg	HCPCS	Procedure
J9304	Injection, pemetrexed (Pemfexy), 10 mg	HCPCS	Procedure
J9305	Injection, pemetrexed, NOS, 10 mg	HCPCS	Procedure
J9306	Injection, pertuzumab, 1 mg	HCPCS	Procedure
J9307	Injection, pralatrexate, 1 mg	HCPCS	Procedure
J9308	Injection, ramucirumab, 5 mg	HCPCS	Procedure
J9309	Injection, polatuzumab vedotin-piiq, 1 mg	HCPCS	Procedure
J9310	Injection, rituximab, 100 mg	HCPCS	Procedure
J9311	Injection, rituximab 10 mg and hyaluronidase	HCPCS	Procedure
J9312	Injection, rituximab, 10 mg	HCPCS	Procedure
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	HCPCS	Procedure

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
J9315	Injection, romidepsin, 1 mg	HCPCS	Procedure
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	HCPCS	Procedure
J9317	Injection, sacituzumab govitecan-hziy, 2.5 mg	HCPCS	Procedure
J9318	Injection, romidepsin, nonlyophilized, 0.1 mg	HCPCS	Procedure
J9319	Injection, romidepsin, lyophilized, 0.1 mg	HCPCS	Procedure
J9320	Injection, streptozocin, 1 g	HCPCS	Procedure
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units	HCPCS	Procedure
J9328	Injection, temozolomide, 1 mg	HCPCS	Procedure
J9330	Injection, temsirolimus, 1 mg	HCPCS	Procedure
J9331	Injection, sirolimus protein-bound particles, 1 mg	HCPCS	Procedure
J9332	Injection, efgartigimod alfa-fcab, 2 mg	HCPCS	Procedure
J9340	Injection, thiotepa, 15 mg	HCPCS	Procedure
J9348	Injection, naxitamab-gqgk, 1 mg	HCPCS	Procedure
J9349	Injection, tafasitamab-cxix, 2 mg	HCPCS	Procedure
J9350	Injection, mosunetuzumab-axgb, 1 mg	HCPCS	Procedure
J9351	Injection, topotecan, 0.1 mg	HCPCS	Procedure
J9352	Injection, trabectedin, 0.1 mg	HCPCS	Procedure
J9353	Injection, margetuximab-cmkb, 5 mg	HCPCS	Procedure
J9354	Injection, ado-trastuzumab emtansine, 1 mg	HCPCS	Procedure
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg	HCPCS	Procedure
J9356	Injection, trastuzumab, 10 mg and hyaluronidase-oysk	HCPCS	Procedure
J9357	Injection, valrubicin, intravesical, 200 mg	HCPCS	Procedure
J9358	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg	HCPCS	Procedure
J9359	Injection, loncastuximab tesirine-lpyl, 0.075 mg	HCPCS	Procedure
J9360	Injection, vinblastine sulfate, 1 mg	HCPCS	Procedure
J9370	Vincristine sulfate, 1 mg	HCPCS	Procedure
J9371	Injection, vincristine sulfate liposome, 1 mg	HCPCS	Procedure
J9375	Vincristine sulfate, 2 mg	HCPCS	Procedure
J9380	Injection, teclistamab-cqyv, 0.5 mg	HCPCS	Procedure
J9390	Injection, vinorelbine tartrate, 10 mg	HCPCS	Procedure
J9393	Injection, fulvestrant (Teva) not therapeutically equivalent to J9395, 25 mg	HCPCS	Procedure
J9394	Injection, fulvestrant (Fresenius Kabi) not therapeutically equivalent to J9395, 25 mg	HCPCS	Procedure
J9395	Injection, fulvestrant, 25 mg	HCPCS	Procedure
J9400	Injection, ziv-aflibercept, 1 mg	HCPCS	Procedure
J9600	Injection, porfimer sodium, 75 mg	HCPCS	Procedure
M1072	Radiation therapy for anal cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1073	Radiation therapy for anal cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure

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Code	Description	Code Type	Code Category
M1074	Radiation therapy for bladder cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1075	Radiation therapy for bladder cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1080	Radiation therapy for breast cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1081	Radiation therapy for breast cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1082	Radiation therapy for cervical cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1083	Radiation therapy for cervical cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1084	Radiation therapy for CNS tumors under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1085	Radiation therapy for CNS tumors under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1086	Radiation therapy for colorectal cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1087	Radiation therapy for colorectal cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1088	Radiation therapy for head and neck cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1089	Radiation therapy for head and neck cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1094	Radiation therapy for lung cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1095	Radiation therapy for lung cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1098	Radiation therapy for pancreatic cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1099	Radiation therapy for pancreatic cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1100	Radiation therapy for prostate cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1101	Radiation therapy for prostate cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1102	Radiation therapy for upper GI cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure
M1103	Radiation therapy for upper GI cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
M1104	Radiation therapy for uterine cancer under the Radiation Oncology model, 90-day episode, professional component	HCPCS	Procedure

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Code	Description	Code Type	Code Category
M1105	Radiation therapy for uterine cancer under the Radiation Oncology model, 90-day episode, technical component	HCPCS	Procedure
Q0083	Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit	HCPCS	Procedure
Q0084	Chemotherapy administration by infusion technique only, per visit	HCPCS	Procedure
Q0085	Chemotherapy administration by both infusion technique and other technique(s) (e.g. subcutaneous, intramuscular, push), per visit	HCPCS	Procedure
Q2025	Fludarabine phosphate, oral, 1 mg	HCPCS	Procedure
Q2048	Injection, doxorubicin hydrochloride, liposomal, DOXIL, 10 mg	HCPCS	Procedure
Q2049	Injection, doxorubicin HCl, liposomal, imported Lipodox, 10 mg	HCPCS	Procedure
Q2050	Injection, doxorubicin HCl, liposomal, not otherwise specified, 10 mg	HCPCS	Procedure
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg	HCPCS	Procedure
Q5113	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg	HCPCS	Procedure
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg	HCPCS	Procedure
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	HCPCS	Procedure
Q5116	Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg	HCPCS	Procedure
Q5117	Injection, trastuzumab-anns, biosimilar, (Kanjinti), 10 mg	HCPCS	Procedure
Q9979	Injection, Alemtuzumab, 1 mg	HCPCS	Procedure
S0087	Injection, alemtuzumab, 30 mg	HCPCS	Procedure
S0088	Imatinib, 100 mg	HCPCS	Procedure
S0108	Mercaptopurine, oral, 50 mg	HCPCS	Procedure
S0115	Bortezomib, 3.5 mg	HCPCS	Procedure
S0116	Bevacizumab, 100 mg	HCPCS	Procedure
S0168	Injection, azacitidine, 100 mg	HCPCS	Procedure
S0172	Chlorambucil, oral, 2 mg	HCPCS	Procedure
S0176	Hydroxyurea, oral, 500 mg	HCPCS	Procedure
S0178	Lomustine, oral, 10 mg	HCPCS	Procedure
S5019	Chemotherapy administration supplies (with pump), per diem	HCPCS	Procedure
S5020	Chemotherapy administration supplies (without pump), per diem	HCPCS	Procedure
S9329	Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with S9330 or S9331)	HCPCS	Procedure
S9330	Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	HCPCS	Procedure

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Code	Description	Code Type	Code Category
S9331	Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	HCPCS	Procedure
S9359	Home infusion therapy, antitumor necrosis factor intravenous therapy; (e.g., Infliximab); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	HCPCS	Procedure
XW03351	Introduction of Blinatumomab Antineoplastic Immunotherapy into Peripheral Vein, Percutaneous Approach, New Technology Group 1	ICD-10-PCS	Procedure
XW033B3	Introduction of Cytarabine and Daunorubicin Liposome Antineoplastic into Peripheral Vein, Percutaneous Approach, New Technology Group 3	ICD-10-PCS	Procedure
XW033C3	Introduction of Engineered Autologous Chimeric Antigen Receptor T-cell Immunotherapy into Peripheral Vein, Percutaneous Approach, New Technology Group 3	ICD-10-PCS	Procedure
XW033Q5	Introduction of Tagraxofusp-erzs Antineoplastic into Peripheral Vein, Percutaneous Approach, New Technology Group 5	ICD-10-PCS	Procedure
XW033S5	Introduction of Iobenguane I-131 Antineoplastic into Peripheral Vein, Percutaneous Approach, New Technology Group 5	ICD-10-PCS	Procedure
XW04351	Introduction of Blinatumomab Antineoplastic Immunotherapy into Central Vein, Percutaneous Approach, New Technology Group 1	ICD-10-PCS	Procedure
XW043B3	Introduction of Cytarabine and Daunorubicin Liposome Antineoplastic into Central Vein, Percutaneous Approach, New Technology Group 3	ICD-10-PCS	Procedure
XW043C3	Introduction of Engineered Autologous Chimeric Antigen Receptor T-cell Immunotherapy into Central Vein, Percutaneous Approach, New Technology Group 3	ICD-10-PCS	Procedure
XW043Q5	Introduction of Tagraxofusp-erzs Antineoplastic into Central Vein, Percutaneous Approach, New Technology Group 5	ICD-10-PCS	Procedure
XW043S5	Introduction of Iobenguane I-131 Antineoplastic into Central Vein, Percutaneous Approach, New Technology Group 5	ICD-10-PCS	Procedure
XW0DXL5	Introduction of Erdafitinib Antineoplastic into Mouth and Pharynx, External Approach, New Technology Group 5	ICD-10-PCS	Procedure
XW0DXR5	Introduction of Venetoclax Antineoplastic into Mouth and Pharynx, External Approach, New Technology Group 5	ICD-10-PCS	Procedure
XW0DXT5	Introduction of Ruxolitinib into Mouth and Pharynx, External Approach, New Technology Group 5	ICD-10-PCS	Procedure

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Code	Description	Code Type	Code Category
XW0DXV5	Introduction of Gilteritinib Antineoplastic into Mouth and Pharynx, External Approach, New Technology Group 5	ICD-10-PCS	Procedure
00.10	Implantation of chemotherapeutic agent	ICD-9-CM	Procedure
00.18	Infusion of immunosuppressive antibody therapy	ICD-9-CM	Procedure
17.70	Intravenous infusion of clofarabine	ICD-9-CM	Procedure
39.96	Total body perfusion	ICD-9-CM	Procedure
39.97	Other perfusion	ICD-9-CM	Procedure
41.02	Allogeneic bone marrow transplant with purging	ICD-9-CM	Procedure
41.07	Autologous hematopoietic stem cell transplant with purging	ICD-9-CM	Procedure
41.08	Allogeneic hematopoietic stem cell transplant with purging	ICD-9-CM	Procedure
41.09	Autologous bone marrow transplant with purging	ICD-9-CM	Procedure
75.37	Amnioinfusion	ICD-9-CM	Procedure
99.25	Injection or infusion of cancer chemotherapeutic substance	ICD-9-CM	Procedure
99.28	Injection or infusion of biological response modifier [BRM] as an antineoplastic agent	ICD-9-CM	Procedure
	Inpatient Serious Infection		
003.1	Salmonella septicemia	ICD-9-CM	Diagnosis
003.21	Salmonella meningitis	ICD-9-CM	Diagnosis
003.24	Salmonella osteomyelitis	ICD-9-CM	Diagnosis
008.1	Intestinal infection due to Arizona group of paracolon bacilli	ICD-9-CM	Diagnosis
008.2	Intestinal infection due to aerobacter aerogenes	ICD-9-CM	Diagnosis
008.3	Intestinal infections due to proteus (mirabilis) (morganii)	ICD-9-CM	Diagnosis
008.41	Intestinal infections due to staphylococcus	ICD-9-CM	Diagnosis
008.42	Intestinal infections due to pseudomonas	ICD-9-CM	Diagnosis
008.46	Intestinal infections due to other anaerobes	ICD-9-CM	Diagnosis
008.47	Intestinal infections due to other gram-negative bacteria	ICD-9-CM	Diagnosis
008.49	Intestinal infection due to other organisms	ICD-9-CM	Diagnosis
008.5	Intestinal infection due to unspecified bacterial enteritis	ICD-9-CM	Diagnosis
013.00	Tuberculous meningitis, confirmation unspecified	ICD-9-CM	Diagnosis
013.01	Tuberculous meningitis, bacteriological or histological examination not done	ICD-9-CM	Diagnosis
013.02	Tuberculous meningitis, bacteriological or histological examination unknown (at present)	ICD-9-CM	Diagnosis
013.03	Tuberculous meningitis, tubercle bacilli found (in sputum) by microscopy	ICD-9-CM	Diagnosis
013.04	Tuberculous meningitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture	ICD-9-CM	Diagnosis
013.05	Tuberculous meningitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically	ICD-9-CM	Diagnosis
013.06	Tuberculous meningitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods [inoculation of animals]	ICD-9-CM	Diagnosis
027.0	Listeriosis	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
031.1	Cutaneous diseases due to other mycobacteria	ICD-9-CM	Diagnosis
032.85	Cutaneous diphtheria	ICD-9-CM	Diagnosis
035	Erysipelas	ICD-9-CM	Diagnosis
036.0	Meningococcal meningitis	ICD-9-CM	Diagnosis
036.2	Meningococcemia	ICD-9-CM	Diagnosis
036.42	Meningococcal endocarditis	ICD-9-CM	Diagnosis
038.0	Streptococcal septicemia	ICD-9-CM	Diagnosis
038.10	Unspecified staphylococcal septicemia	ICD-9-CM	Diagnosis
038.11	Methicillin susceptible Staphylococcus aureus septicemia	ICD-9-CM	Diagnosis
038.12	Methicillin resistant Staphylococcus aureus septicemia	ICD-9-CM	Diagnosis
038.19	Other staphylococcal septicemia	ICD-9-CM	Diagnosis
038.2	Pneumococcal septicemia	ICD-9-CM	Diagnosis
038.3	Septicemia due to anaerobes	ICD-9-CM	Diagnosis
038.40	Septicemia due to unspecified gram-negative organism	ICD-9-CM	Diagnosis
038.41	Septicemia due to hemophilus influenzae (H. influenzae)	ICD-9-CM	Diagnosis
038.42	Septicemia due to Escherichia coli (E. coli)	ICD-9-CM	Diagnosis
038.43	Septicemia due to pseudomonas	ICD-9-CM	Diagnosis
038.44	Septicemia due to serratia	ICD-9-CM	Diagnosis
038.49	Other septicemia due to gram-negative organism	ICD-9-CM	Diagnosis
038.8	Other specified septicemia	ICD-9-CM	Diagnosis
038.9	Unspecified septicemia	ICD-9-CM	Diagnosis
039.0	Cutaneous actinomycotic infection	ICD-9-CM	Diagnosis
040.0	Gas gangrene	ICD-9-CM	Diagnosis
047.0	Meningitis due to coxsackie virus	ICD-9-CM	Diagnosis
047.1	Meningitis due to ECHO virus	ICD-9-CM	Diagnosis
047.8	Other specified viral meningitis	ICD-9-CM	Diagnosis
047.9	Unspecified viral meningitis	ICD-9-CM	Diagnosis
049.0	Lymphocytic choriomeningitis	ICD-9-CM	Diagnosis
049.1	Meningitis due to adenovirus	ICD-9-CM	Diagnosis
053.0	Herpes zoster with meningitis	ICD-9-CM	Diagnosis
054.72	Herpes simplex meningitis	ICD-9-CM	Diagnosis
072.1	Mumps meningitis	ICD-9-CM	Diagnosis
074.22	Coxsackie endocarditis	ICD-9-CM	Diagnosis
086.1	Chagas' disease with other organ involvement	ICD-9-CM	Diagnosis
098.89	Gonococcal infection of other specified sites	ICD-9-CM	Diagnosis
100.81	Leptospiral meningitis (aseptic)	ICD-9-CM	Diagnosis
112.5	Disseminated candidiasis	ICD-9-CM	Diagnosis
112.81	Candidal endocarditis	ICD-9-CM	Diagnosis
112.83	Candidal meningitis	ICD-9-CM	Diagnosis
114.2	Coccidioidal meningitis	ICD-9-CM	Diagnosis
115.01	Histoplasma capsulatum meningitis	ICD-9-CM	Diagnosis
115.11	Histoplasma duboisii meningitis	ICD-9-CM	Diagnosis
115.91	Unspecified Histoplasmosis meningitis	ICD-9-CM	Diagnosis
320.0	Hemophilus meningitis	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
320.1	Pneumococcal meningitis	ICD-9-CM	Diagnosis
320.2	Streptococcal meningitis	ICD-9-CM	Diagnosis
320.3	Staphylococcal meningitis	ICD-9-CM	Diagnosis
320.7	Meningitis in other bacterial diseases classified elsewhere	ICD-9-CM	Diagnosis
320.81	Anaerobic meningitis	ICD-9-CM	Diagnosis
320.82	Meningitis due to gram-negative bacteria, not elsewhere classified	ICD-9-CM	Diagnosis
320.89	Meningitis due to other specified bacteria	ICD-9-CM	Diagnosis
320.9	Meningitis due to unspecified bacterium	ICD-9-CM	Diagnosis
321.0	Cryptococcal meningitis	ICD-9-CM	Diagnosis
321.1	Meningitis in other fungal diseases	ICD-9-CM	Diagnosis
321.2	Meningitis due to viruses not elsewhere classified	ICD-9-CM	Diagnosis
321.3	Meningitis due to trypanosomiasis	ICD-9-CM	Diagnosis
321.4	Meningitis in sarcoidosis	ICD-9-CM	Diagnosis
321.8	Meningitis due to other nonbacterial organisms classified elsewhere	ICD-9-CM	Diagnosis
322.1	Eosinophilic meningitis	ICD-9-CM	Diagnosis
322.9	Unspecified meningitis	ICD-9-CM	Diagnosis
373.13	Abscess of eyelid	ICD-9-CM	Diagnosis
376.01	Orbital cellulitis	ICD-9-CM	Diagnosis
376.03	Orbital osteomyelitis	ICD-9-CM	Diagnosis
421.0	Acute and subacute bacterial endocarditis	ICD-9-CM	Diagnosis
440.24	Atherosclerosis of native arteries of the extremities with gangrene	ICD-9-CM	Diagnosis
449	Septic arterial embolism	ICD-9-CM	Diagnosis
513.0	Abscess of lung	ICD-9-CM	Diagnosis
528.00	Stomatitis and mucositis, unspecified	ICD-9-CM	Diagnosis
528.3	Cellulitis and abscess of oral soft tissues	ICD-9-CM	Diagnosis
540.0	Acute appendicitis with generalized peritonitis	ICD-9-CM	Diagnosis
540.1	Acute appendicitis with peritoneal abscess	ICD-9-CM	Diagnosis
540.9	Acute appendicitis without mention of peritonitis	ICD-9-CM	Diagnosis
541	Appendicitis, unqualified	ICD-9-CM	Diagnosis
542	Other appendicitis	ICD-9-CM	Diagnosis
543.9	Other and unspecified diseases of appendix	ICD-9-CM	Diagnosis
562.01	Diverticulitis of small intestine (without mention of hemorrhage)	ICD-9-CM	Diagnosis
562.03	Diverticulitis of small intestine with hemorrhage	ICD-9-CM	Diagnosis
562.11	Diverticulitis of colon (without mention of hemorrhage)	ICD-9-CM	Diagnosis
562.13	Diverticulitis of colon with hemorrhage	ICD-9-CM	Diagnosis
566	Abscess of anal and rectal regions	ICD-9-CM	Diagnosis
567.1	Pneumococcal peritonitis	ICD-9-CM	Diagnosis
567.21	Peritonitis (acute) generalized	ICD-9-CM	Diagnosis
567.22	Peritoneal abscess	ICD-9-CM	Diagnosis
567.23	Spontaneous bacterial peritonitis	ICD-9-CM	Diagnosis

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Code	Description	Code Type	Code Category
567.29	Other suppurative peritonitis	ICD-9-CM	Diagnosis
567.38	Other retroperitoneal abscess	ICD-9-CM	Diagnosis
567.81	Choleperitonitis	ICD-9-CM	Diagnosis
567.89	Other specified peritonitis	ICD-9-CM	Diagnosis
567.9	Unspecified peritonitis	ICD-9-CM	Diagnosis
569.5	Abscess of intestine	ICD-9-CM	Diagnosis
572.0	Abscess of liver	ICD-9-CM	Diagnosis
575.0	Acute cholecystitis	ICD-9-CM	Diagnosis
575.10	Cholecystitis, unspecified	ICD-9-CM	Diagnosis
575.12	Acute and chronic cholecystitis	ICD-9-CM	Diagnosis
577.0	Acute pancreatitis	ICD-9-CM	Diagnosis
583.81	Nephritis and nephropathy, not specified as acute or chronic, with other specified pathological lesion in kidney, in diseases classified elsewhere	ICD-9-CM	Diagnosis
590.10	Acute pyelonephritis without lesion of renal medullary necrosis	ICD-9-CM	Diagnosis
590.11	Acute pyelonephritis with lesion of renal medullary necrosis	ICD-9-CM	Diagnosis
590.81	Pyelitis or pyelonephritis in diseases classified elsewhere	ICD-9-CM	Diagnosis
614.3	Acute parametritis and pelvic cellulitis	ICD-9-CM	Diagnosis
614.4	Chronic or unspecified parametritis and pelvic cellulitis	ICD-9-CM	Diagnosis
680.0	Carbuncle and furuncle of face	ICD-9-CM	Diagnosis
680.1	Carbuncle and furuncle of neck	ICD-9-CM	Diagnosis
680.2	Carbuncle and furuncle of trunk	ICD-9-CM	Diagnosis
680.3	Carbuncle and furuncle of upper arm and forearm	ICD-9-CM	Diagnosis
680.4	Carbuncle and furuncle of hand	ICD-9-CM	Diagnosis
680.5	Carbuncle and furuncle of buttock	ICD-9-CM	Diagnosis
680.6	Carbuncle and furuncle of leg, except foot	ICD-9-CM	Diagnosis
680.7	Carbuncle and furuncle of foot	ICD-9-CM	Diagnosis
680.8	Carbuncle and furuncle of other specified sites	ICD-9-CM	Diagnosis
680.9	Carbuncle and furuncle of unspecified site	ICD-9-CM	Diagnosis
681.00	Unspecified cellulitis and abscess of finger	ICD-9-CM	Diagnosis
681.01	Felon	ICD-9-CM	Diagnosis
681.02	Onychia and paronychia of finger	ICD-9-CM	Diagnosis
681.10	Unspecified cellulitis and abscess of toe	ICD-9-CM	Diagnosis
681.11	Onychia and paronychia of toe	ICD-9-CM	Diagnosis
681.9	Cellulitis and abscess of unspecified digit	ICD-9-CM	Diagnosis
682.0	Cellulitis and abscess of face	ICD-9-CM	Diagnosis
682.1	Cellulitis and abscess of neck	ICD-9-CM	Diagnosis
682.2	Cellulitis and abscess of trunk	ICD-9-CM	Diagnosis
682.3	Cellulitis and abscess of upper arm and forearm	ICD-9-CM	Diagnosis
682.4	Cellulitis and abscess of hand, except fingers and thumb	ICD-9-CM	Diagnosis
682.5	Cellulitis and abscess of buttock	ICD-9-CM	Diagnosis
682.6	Cellulitis and abscess of leg, except foot	ICD-9-CM	Diagnosis
682.7	Cellulitis and abscess of foot, except toes	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
682.8	Cellulitis and abscess of other specified site	ICD-9-CM	Diagnosis
682.9	Cellulitis and abscess of unspecified site	ICD-9-CM	Diagnosis
684	Impetigo	ICD-9-CM	Diagnosis
685.0	Pilonidal cyst with abscess	ICD-9-CM	Diagnosis
685.1	Pilonidal cyst without mention of abscess	ICD-9-CM	Diagnosis
686.09	Other pyoderma	ICD-9-CM	Diagnosis
686.8	Other specified local infections of skin and subcutaneous tissue	ICD-9-CM	Diagnosis
686.9	Unspecified local infection of skin and subcutaneous tissue	ICD-9-CM	Diagnosis
728.86	Necrotizing fasciitis	ICD-9-CM	Diagnosis
730.00	Acute osteomyelitis, site unspecified	ICD-9-CM	Diagnosis
730.01	Acute osteomyelitis, shoulder region	ICD-9-CM	Diagnosis
730.02	Acute osteomyelitis, upper arm	ICD-9-CM	Diagnosis
730.03	Acute osteomyelitis, forearm	ICD-9-CM	Diagnosis
730.04	Acute osteomyelitis, hand	ICD-9-CM	Diagnosis
730.05	Acute osteomyelitis, pelvic region and thigh	ICD-9-CM	Diagnosis
730.06	Acute osteomyelitis, lower leg	ICD-9-CM	Diagnosis
730.07	Acute osteomyelitis, ankle and foot	ICD-9-CM	Diagnosis
730.08	Acute osteomyelitis, other specified site	ICD-9-CM	Diagnosis
730.09	Acute osteomyelitis, multiple sites	ICD-9-CM	Diagnosis
730.10	Chronic osteomyelitis, site unspecified	ICD-9-CM	Diagnosis
730.11	Chronic osteomyelitis, shoulder region	ICD-9-CM	Diagnosis
730.12	Chronic osteomyelitis, upper arm	ICD-9-CM	Diagnosis
730.13	Chronic osteomyelitis, forearm	ICD-9-CM	Diagnosis
730.14	Chronic osteomyelitis, hand	ICD-9-CM	Diagnosis
730.15	Chronic osteomyelitis, pelvic region and thigh	ICD-9-CM	Diagnosis
730.16	Chronic osteomyelitis, lower leg	ICD-9-CM	Diagnosis
730.17	Chronic osteomyelitis, ankle and foot	ICD-9-CM	Diagnosis
730.18	Chronic osteomyelitis, other specified sites	ICD-9-CM	Diagnosis
730.19	Chronic osteomyelitis, multiple sites	ICD-9-CM	Diagnosis
730.20	Unspecified osteomyelitis, site unspecified	ICD-9-CM	Diagnosis
730.21	Unspecified osteomyelitis, shoulder region	ICD-9-CM	Diagnosis
730.22	Unspecified osteomyelitis, upper arm	ICD-9-CM	Diagnosis
730.23	Unspecified osteomyelitis, forearm	ICD-9-CM	Diagnosis
730.24	Unspecified osteomyelitis, hand	ICD-9-CM	Diagnosis
730.25	Unspecified osteomyelitis, pelvic region and thigh	ICD-9-CM	Diagnosis
730.26	Unspecified osteomyelitis, lower leg	ICD-9-CM	Diagnosis
730.27	Unspecified osteomyelitis, ankle and foot	ICD-9-CM	Diagnosis
730.28	Unspecified osteomyelitis, other specified sites	ICD-9-CM	Diagnosis
730.29	Unspecified osteomyelitis, multiple sites	ICD-9-CM	Diagnosis
730.90	Unspecified infection of bone, site unspecified	ICD-9-CM	Diagnosis
730.91	Unspecified infection of bone, shoulder region	ICD-9-CM	Diagnosis
730.92	Unspecified infection of bone, upper arm	ICD-9-CM	Diagnosis
730.93	Unspecified infection of bone, forearm	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
730.94	Unspecified infection of bone, hand	ICD-9-CM	Diagnosis
730.95	Unspecified infection of bone, pelvic region and thigh	ICD-9-CM	Diagnosis
730.96	Unspecified infection of bone, lower leg	ICD-9-CM	Diagnosis
730.97	Unspecified infection of bone, ankle and foot	ICD-9-CM	Diagnosis
730.98	Unspecified infection of bone of other specified site	ICD-9-CM	Diagnosis
730.99	Unspecified infection of bone in multiple sites	ICD-9-CM	Diagnosis
771.83	Bacteremia of newborn	ICD-9-CM	Diagnosis
785.4	Gangrene	ICD-9-CM	Diagnosis
785.52	Septic shock	ICD-9-CM	Diagnosis
790.7	Bacteremia	ICD-9-CM	Diagnosis
910.1	Face, neck, and scalp except eye, abrasion or friction burn, infected	ICD-9-CM	Diagnosis
910.3	Face, neck, and scalp except eye, blister, infected	ICD-9-CM	Diagnosis
910.5	Face, neck, and scalp except eye, insect bite, nonvenomous, infected	ICD-9-CM	Diagnosis
910.7	Face, neck, and scalp except eye, superficial foreign body (splinter), without major open wound, infected	ICD-9-CM	Diagnosis
910.9	Other and unspecified superficial injury of face, neck, and scalp, infected	ICD-9-CM	Diagnosis
911.1	Trunk abrasion or friction burn, infected	ICD-9-CM	Diagnosis
911.3	Trunk blister, infected	ICD-9-CM	Diagnosis
911.5	Trunk, insect bite, nonvenomous, infected	ICD-9-CM	Diagnosis
911.7	Trunk, superficial foreign body (splinter), without major open wound, infected	ICD-9-CM	Diagnosis
911.9	Other and unspecified superficial injury of trunk, infected	ICD-9-CM	Diagnosis
912.1	Shoulder and upper arm, abrasion or friction burn, infected	ICD-9-CM	Diagnosis
912.3	Shoulder and upper arm, blister, infected	ICD-9-CM	Diagnosis
912.5	Shoulder and upper arm, insect bite, nonvenomous, infected	ICD-9-CM	Diagnosis
912.7	Shoulder and upper arm, superficial foreign body (splinter), without major open wound, infected	ICD-9-CM	Diagnosis
912.9	Other and unspecified superficial injury of shoulder and upper arm, infected	ICD-9-CM	Diagnosis
913.1	Elbow, forearm, and wrist, abrasion or friction burn, infected	ICD-9-CM	Diagnosis
913.3	Elbow, forearm, and wrist, blister infected	ICD-9-CM	Diagnosis
913.5	Elbow, forearm, and wrist, insect bite, nonvenomous, infected	ICD-9-CM	Diagnosis
913.7	Elbow, forearm, and wrist, superficial foreign body (splinter), without major open wound, infected	ICD-9-CM	Diagnosis
913.9	Other and unspecified superficial injury of elbow, forearm, and wrist, infected	ICD-9-CM	Diagnosis
914.1	Hand(s) except finger(s) alone, abrasion or friction burn, infected	ICD-9-CM	Diagnosis
914.3	Hand(s) except finger(s) alone, blister, infected	ICD-9-CM	Diagnosis
914.5	Hand(s) except finger(s) alone, insect bite, nonvenomous, infected	ICD-9-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
914.7	Hand(s) except finger(s) alone, superficial foreign body (splinter) without major open wound, infected	ICD-9-CM	Diagnosis
914.9	Other and unspecified superficial injury of hand(s) except finger(s) alone, infected	ICD-9-CM	Diagnosis
915.1	Finger, abrasion or friction burn, infected	ICD-9-CM	Diagnosis
915.3	Finger, blister, infected	ICD-9-CM	Diagnosis
915.5	Finger, insect bite, nonvenomous, infected	ICD-9-CM	Diagnosis
915.7	Finger, superficial foreign body (splinter), without major open wound, infected	ICD-9-CM	Diagnosis
915.9	Other and unspecified superficial injury of finger, infected	ICD-9-CM	Diagnosis
916.1	Hip, thigh, leg, and ankle, abrasion or friction burn, infected	ICD-9-CM	Diagnosis
916.3	Hip, thigh, leg, and ankle, blister, infected	ICD-9-CM	Diagnosis
916.5	Hip, thigh, leg, and ankle, insect bite, nonvenomous, infected	ICD-9-CM	Diagnosis
916.7	Hip, thigh, leg, and ankle, superficial foreign body (splinter), without major open wound, infected	ICD-9-CM	Diagnosis
916.9	Other and unspecified superficial injury of hip, thigh, leg, and ankle, infected	ICD-9-CM	Diagnosis
917.1	Foot and toe(s), abrasion or friction burn, infected	ICD-9-CM	Diagnosis
917.3	Foot and toe(s), blister, infected	ICD-9-CM	Diagnosis
917.5	Foot and toe(s), insect bite, nonvenomous, infected	ICD-9-CM	Diagnosis
917.7	Foot and toe(s), superficial foreign body (splinter), without major open wound, infected	ICD-9-CM	Diagnosis
917.9	Other and unspecified superficial injury of foot and toes, infected	ICD-9-CM	Diagnosis
919.1	Other, multiple, and unspecified sites, abrasion or friction burn, infected	ICD-9-CM	Diagnosis
919.3	Other, multiple, and unspecified sites, blister, infected	ICD-9-CM	Diagnosis
919.5	Other, multiple, and unspecified sites, insect bite, nonvenomous, infected	ICD-9-CM	Diagnosis
919.7	Other, multiple, and unspecified sites, superficial foreign body (splinter), without major open wound, infected	ICD-9-CM	Diagnosis
919.9	Other and unspecified superficial injury of other, multiple, and unspecified sites, infected	ICD-9-CM	Diagnosis
995.91	Sepsis	ICD-9-CM	Diagnosis
995.92	Severe sepsis	ICD-9-CM	Diagnosis
997.09	Other nervous system complications	ICD-9-CM	Diagnosis
A01.01	Typhoid meningitis	ICD-10-CM	Diagnosis
A01.05	Typhoid osteomyelitis	ICD-10-CM	Diagnosis
A02.1	Salmonella sepsis	ICD-10-CM	Diagnosis
A02.21	Salmonella meningitis	ICD-10-CM	Diagnosis
A02.24	Salmonella osteomyelitis	ICD-10-CM	Diagnosis
A04.8	Other specified bacterial intestinal infections	ICD-10-CM	Diagnosis
A04.9	Bacterial intestinal infection, unspecified	ICD-10-CM	Diagnosis
A17.0	Tuberculous meningitis	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
A20.3	Plague meningitis	ICD-10-CM	Diagnosis
A27.81	Aseptic meningitis in leptospirosis	ICD-10-CM	Diagnosis
A31.1	Cutaneous mycobacterial infection	ICD-10-CM	Diagnosis
A32.11	Listerial meningitis	ICD-10-CM	Diagnosis
A32.7	Listerial sepsis	ICD-10-CM	Diagnosis
A32.82	Listerial endocarditis	ICD-10-CM	Diagnosis
A36.3	Cutaneous diphtheria	ICD-10-CM	Diagnosis
A39.0	Meningococcal meningitis	ICD-10-CM	Diagnosis
A39.2	Acute meningococcemia	ICD-10-CM	Diagnosis
A39.4	Meningococcemia, unspecified	ICD-10-CM	Diagnosis
A39.51	Meningococcal endocarditis	ICD-10-CM	Diagnosis
A40.0	Sepsis due to streptococcus, group A	ICD-10-CM	Diagnosis
A40.1	Sepsis due to streptococcus, group B	ICD-10-CM	Diagnosis
A40.3	Sepsis due to Streptococcus pneumoniae	ICD-10-CM	Diagnosis
A40.8	Other streptococcal sepsis	ICD-10-CM	Diagnosis
A40.9	Streptococcal sepsis, unspecified	ICD-10-CM	Diagnosis
A41.01	Sepsis due to Methicillin susceptible Staphylococcus aureus	ICD-10-CM	Diagnosis
A41.02	Sepsis due to Methicillin resistant Staphylococcus aureus	ICD-10-CM	Diagnosis
A41.1	Sepsis due to other specified staphylococcus	ICD-10-CM	Diagnosis
A41.2	Sepsis due to unspecified staphylococcus	ICD-10-CM	Diagnosis
A41.3	Sepsis due to Hemophilus influenzae	ICD-10-CM	Diagnosis
A41.4	Sepsis due to anaerobes	ICD-10-CM	Diagnosis
A41.50	Gram-negative sepsis, unspecified	ICD-10-CM	Diagnosis
A41.51	Sepsis due to Escherichia coli [E. coli]	ICD-10-CM	Diagnosis
A41.52	Sepsis due to Pseudomonas	ICD-10-CM	Diagnosis
A41.53	Sepsis due to Serratia	ICD-10-CM	Diagnosis
A41.59	Other Gram-negative sepsis	ICD-10-CM	Diagnosis
A41.81	Sepsis due to Enterococcus	ICD-10-CM	Diagnosis
A41.89	Other specified sepsis	ICD-10-CM	Diagnosis
A41.9	Sepsis, unspecified organism	ICD-10-CM	Diagnosis
A42.7	Actinomycotic sepsis	ICD-10-CM	Diagnosis
A42.81	Actinomycotic meningitis	ICD-10-CM	Diagnosis
A43.1	Cutaneous nocardiosis	ICD-10-CM	Diagnosis
A46	Erysipelas	ICD-10-CM	Diagnosis
A48.0	Gas gangrene	ICD-10-CM	Diagnosis
A54.86	Gonococcal sepsis	ICD-10-CM	Diagnosis
A69.21	Meningitis due to Lyme disease	ICD-10-CM	Diagnosis
A74.81	Chlamydial peritonitis	ICD-10-CM	Diagnosis
A87.0	Enteroviral meningitis	ICD-10-CM	Diagnosis
A87.1	Adenoviral meningitis	ICD-10-CM	Diagnosis
A87.2	Lymphocytic choriomeningitis	ICD-10-CM	Diagnosis
A87.8	Other viral meningitis	ICD-10-CM	Diagnosis
A87.9	Viral meningitis, unspecified	ICD-10-CM	Diagnosis
B00.3	Herpesviral meningitis	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
B01.0	Varicella meningitis	ICD-10-CM	Diagnosis
B02.1	Zoster meningitis	ICD-10-CM	Diagnosis
B05.1	Measles complicated by meningitis	ICD-10-CM	Diagnosis
B06.02	Rubella meningitis	ICD-10-CM	Diagnosis
B26.1	Mumps meningitis	ICD-10-CM	Diagnosis
B27.02	Gammaherpesviral mononucleosis with meningitis	ICD-10-CM	Diagnosis
B27.12	Cytomegaloviral mononucleosis with meningitis	ICD-10-CM	Diagnosis
B27.82	Other infectious mononucleosis with meningitis	ICD-10-CM	Diagnosis
B27.92	Infectious mononucleosis, unspecified with meningitis	ICD-10-CM	Diagnosis
B33.21	Viral endocarditis	ICD-10-CM	Diagnosis
B37.5	Candidal meningitis	ICD-10-CM	Diagnosis
B37.6	Candidal endocarditis	ICD-10-CM	Diagnosis
B37.7	Candidal sepsis	ICD-10-CM	Diagnosis
B38.4	Coccidioidomycosis meningitis	ICD-10-CM	Diagnosis
B45.1	Cerebral cryptococcosis	ICD-10-CM	Diagnosis
B57.41	Meningitis in Chagas' disease	ICD-10-CM	Diagnosis
D73.3	Abscess of spleen	ICD-10-CM	Diagnosis
G00.0	Hemophilus meningitis	ICD-10-CM	Diagnosis
G00.1	Pneumococcal meningitis	ICD-10-CM	Diagnosis
G00.2	Streptococcal meningitis	ICD-10-CM	Diagnosis
G00.3	Staphylococcal meningitis	ICD-10-CM	Diagnosis
G00.8	Other bacterial meningitis	ICD-10-CM	Diagnosis
G00.9	Bacterial meningitis, unspecified	ICD-10-CM	Diagnosis
G01	Meningitis in bacterial diseases classified elsewhere	ICD-10-CM	Diagnosis
G02	Meningitis in other infectious and parasitic diseases classified elsewhere	ICD-10-CM	Diagnosis
G03.8	Meningitis due to other specified causes	ICD-10-CM	Diagnosis
G03.9	Meningitis, unspecified	ICD-10-CM	Diagnosis
H00.031	Abscess of right upper eyelid	ICD-10-CM	Diagnosis
H00.032	Abscess of right lower eyelid	ICD-10-CM	Diagnosis
H00.033	Abscess of eyelid right eye, unspecified eyelid	ICD-10-CM	Diagnosis
H00.034	Abscess of left upper eyelid	ICD-10-CM	Diagnosis
H00.035	Abscess of left lower eyelid	ICD-10-CM	Diagnosis
H00.036	Abscess of eyelid left eye, unspecified eyelid	ICD-10-CM	Diagnosis
H00.039	Abscess of eyelid unspecified eye, unspecified eyelid	ICD-10-CM	Diagnosis
H05.011	Cellulitis of right orbit	ICD-10-CM	Diagnosis
H05.012	Cellulitis of left orbit	ICD-10-CM	Diagnosis
H05.013	Cellulitis of bilateral orbits	ICD-10-CM	Diagnosis
H05.019	Cellulitis of unspecified orbit	ICD-10-CM	Diagnosis
H05.021	Osteomyelitis of right orbit	ICD-10-CM	Diagnosis
H05.022	Osteomyelitis of left orbit	ICD-10-CM	Diagnosis
H05.023	Osteomyelitis of bilateral orbits	ICD-10-CM	Diagnosis
H05.029	Osteomyelitis of unspecified orbit	ICD-10-CM	Diagnosis
H60.00	Abscess of external ear, unspecified ear	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
H60.01	Abscess of right external ear	ICD-10-CM	Diagnosis
H60.02	Abscess of left external ear	ICD-10-CM	Diagnosis
H60.03	Abscess of external ear, bilateral	ICD-10-CM	Diagnosis
H60.10	Cellulitis of external ear, unspecified ear	ICD-10-CM	Diagnosis
H60.11	Cellulitis of right external ear	ICD-10-CM	Diagnosis
H60.12	Cellulitis of left external ear	ICD-10-CM	Diagnosis
H60.13	Cellulitis of external ear, bilateral	ICD-10-CM	Diagnosis
I33.0	Acute and subacute infective endocarditis	ICD-10-CM	Diagnosis
I70.261	Atherosclerosis of native arteries of extremities with gangrene, right leg	ICD-10-CM	Diagnosis
I70.262	Atherosclerosis of native arteries of extremities with gangrene, left leg	ICD-10-CM	Diagnosis
I70.263	Atherosclerosis of native arteries of extremities with gangrene, bilateral legs	ICD-10-CM	Diagnosis
I70.268	Atherosclerosis of native arteries of extremities with gangrene, other extremity	ICD-10-CM	Diagnosis
I70.269	Atherosclerosis of native arteries of extremities with gangrene, unspecified extremity	ICD-10-CM	Diagnosis
I73.01	Raynaud's syndrome with gangrene	ICD-10-CM	Diagnosis
I76	Septic arterial embolism	ICD-10-CM	Diagnosis
I96	Gangrene, not elsewhere classified	ICD-10-CM	Diagnosis
J34.0	Abscess, furuncle and carbuncle of nose	ICD-10-CM	Diagnosis
J85.0	Gangrene and necrosis of lung	ICD-10-CM	Diagnosis
K12.2	Cellulitis and abscess of mouth	ICD-10-CM	Diagnosis
K35.2	Acute appendicitis with generalized peritonitis	ICD-10-CM	Diagnosis
K35.3	Acute appendicitis with localized peritonitis	ICD-10-CM	Diagnosis
K35.80	Unspecified acute appendicitis	ICD-10-CM	Diagnosis
K35.89	Other acute appendicitis	ICD-10-CM	Diagnosis
K36	Other appendicitis	ICD-10-CM	Diagnosis
K37	Unspecified appendicitis	ICD-10-CM	Diagnosis
K38.9	Disease of appendix, unspecified	ICD-10-CM	Diagnosis
K55.30	Necrotizing enterocolitis, unspecified	ICD-10-CM	Diagnosis
K55.31	Stage 1 necrotizing enterocolitis	ICD-10-CM	Diagnosis
K55.32	Stage 2 necrotizing enterocolitis	ICD-10-CM	Diagnosis
K55.33	Stage 3 necrotizing enterocolitis	ICD-10-CM	Diagnosis
K57.00	Diverticulitis of small intestine with perforation and abscess without bleeding	ICD-10-CM	Diagnosis
K57.01	Diverticulitis of small intestine with perforation and abscess with bleeding	ICD-10-CM	Diagnosis
K57.12	Diverticulitis of small intestine without perforation or abscess without bleeding	ICD-10-CM	Diagnosis
K57.13	Diverticulitis of small intestine without perforation or abscess with bleeding	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
K57.20	Diverticulitis of large intestine with perforation and abscess without bleeding	ICD-10-CM	Diagnosis
K57.21	Diverticulitis of large intestine with perforation and abscess with bleeding	ICD-10-CM	Diagnosis
K57.32	Diverticulitis of large intestine without perforation or abscess without bleeding	ICD-10-CM	Diagnosis
K57.33	Diverticulitis of large intestine without perforation or abscess with bleeding	ICD-10-CM	Diagnosis
K57.40	Diverticulitis of both small and large intestine with perforation and abscess without bleeding	ICD-10-CM	Diagnosis
K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding	ICD-10-CM	Diagnosis
K57.52	Diverticulitis of both small and large intestine without perforation or abscess without bleeding	ICD-10-CM	Diagnosis
K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding	ICD-10-CM	Diagnosis
K57.80	Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding	ICD-10-CM	Diagnosis
K57.81	Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding	ICD-10-CM	Diagnosis
K57.92	Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding	ICD-10-CM	Diagnosis
K57.93	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding	ICD-10-CM	Diagnosis
K61.0	Anal abscess	ICD-10-CM	Diagnosis
K61.1	Rectal abscess	ICD-10-CM	Diagnosis
K61.2	Anorectal abscess	ICD-10-CM	Diagnosis
K61.3	Ischiorectal abscess	ICD-10-CM	Diagnosis
K63.0	Abscess of intestine	ICD-10-CM	Diagnosis
K65.0	Generalized (acute) peritonitis	ICD-10-CM	Diagnosis
K65.1	Peritoneal abscess	ICD-10-CM	Diagnosis
K65.2	Spontaneous bacterial peritonitis	ICD-10-CM	Diagnosis
K65.3	Choleperitonitis	ICD-10-CM	Diagnosis
K65.8	Other peritonitis	ICD-10-CM	Diagnosis
K65.9	Peritonitis, unspecified	ICD-10-CM	Diagnosis
K68.19	Other retroperitoneal abscess	ICD-10-CM	Diagnosis
K75.0	Abscess of liver	ICD-10-CM	Diagnosis
K81.0	Acute cholecystitis	ICD-10-CM	Diagnosis
K81.2	Acute cholecystitis with chronic cholecystitis	ICD-10-CM	Diagnosis
K81.9	Cholecystitis, unspecified	ICD-10-CM	Diagnosis
K85.0	Idiopathic acute pancreatitis	ICD-10-CM	Diagnosis
K85.00	Idiopathic acute pancreatitis without necrosis or infection	ICD-10-CM	Diagnosis
K85.01	Idiopathic acute pancreatitis with uninfected necrosis	ICD-10-CM	Diagnosis
K85.02	Idiopathic acute pancreatitis with infected necrosis	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
K85.1	Biliary acute pancreatitis	ICD-10-CM	Diagnosis
K85.10	Biliary acute pancreatitis without necrosis or infection	ICD-10-CM	Diagnosis
K85.11	Biliary acute pancreatitis with uninfected necrosis	ICD-10-CM	Diagnosis
K85.12	Biliary acute pancreatitis with infected necrosis	ICD-10-CM	Diagnosis
K85.3	Drug induced acute pancreatitis	ICD-10-CM	Diagnosis
K85.30	Drug induced acute pancreatitis without necrosis or infection	ICD-10-CM	Diagnosis
K85.31	Drug induced acute pancreatitis with uninfected necrosis	ICD-10-CM	Diagnosis
K85.32	Drug induced acute pancreatitis with infected necrosis	ICD-10-CM	Diagnosis
K85.8	Other acute pancreatitis	ICD-10-CM	Diagnosis
K85.80	Other acute pancreatitis without necrosis or infection	ICD-10-CM	Diagnosis
K85.81	Other acute pancreatitis with uninfected necrosis	ICD-10-CM	Diagnosis
K85.82	Other acute pancreatitis with infected necrosis	ICD-10-CM	Diagnosis
K85.9	Acute pancreatitis, unspecified	ICD-10-CM	Diagnosis
K85.90	Acute pancreatitis without necrosis or infection, unspecified	ICD-10-CM	Diagnosis
K85.91	Acute pancreatitis with uninfected necrosis, unspecified	ICD-10-CM	Diagnosis
K85.92	Acute pancreatitis with infected necrosis, unspecified	ICD-10-CM	Diagnosis
L01.00	Impetigo, unspecified	ICD-10-CM	Diagnosis
L01.01	Non-bullous impetigo	ICD-10-CM	Diagnosis
L01.02	Bockhart's impetigo	ICD-10-CM	Diagnosis
L01.03	Bullous impetigo	ICD-10-CM	Diagnosis
L01.09	Other impetigo	ICD-10-CM	Diagnosis
L01.1	Impetiginization of other dermatoses	ICD-10-CM	Diagnosis
L02.01	Cutaneous abscess of face	ICD-10-CM	Diagnosis
L02.02	Furuncle of face	ICD-10-CM	Diagnosis
L02.03	Carbuncle of face	ICD-10-CM	Diagnosis
L02.11	Cutaneous abscess of neck	ICD-10-CM	Diagnosis
L02.12	Furuncle of neck	ICD-10-CM	Diagnosis
L02.13	Carbuncle of neck	ICD-10-CM	Diagnosis
L02.211	Cutaneous abscess of abdominal wall	ICD-10-CM	Diagnosis
L02.212	Cutaneous abscess of back [any part, except buttock]	ICD-10-CM	Diagnosis
L02.213	Cutaneous abscess of chest wall	ICD-10-CM	Diagnosis
L02.214	Cutaneous abscess of groin	ICD-10-CM	Diagnosis
L02.215	Cutaneous abscess of perineum	ICD-10-CM	Diagnosis
L02.216	Cutaneous abscess of umbilicus	ICD-10-CM	Diagnosis
L02.219	Cutaneous abscess of trunk, unspecified	ICD-10-CM	Diagnosis
L02.221	Furuncle of abdominal wall	ICD-10-CM	Diagnosis
L02.222	Furuncle of back [any part, except buttock]	ICD-10-CM	Diagnosis
L02.223	Furuncle of chest wall	ICD-10-CM	Diagnosis
L02.224	Furuncle of groin	ICD-10-CM	Diagnosis
L02.225	Furuncle of perineum	ICD-10-CM	Diagnosis
L02.226	Furuncle of umbilicus	ICD-10-CM	Diagnosis
L02.229	Furuncle of trunk, unspecified	ICD-10-CM	Diagnosis
L02.231	Carbuncle of abdominal wall	ICD-10-CM	Diagnosis
L02.232	Carbuncle of back [any part, except buttock]	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
L02.233	Carbuncle of chest wall	ICD-10-CM	Diagnosis
L02.234	Carbuncle of groin	ICD-10-CM	Diagnosis
L02.235	Carbuncle of perineum	ICD-10-CM	Diagnosis
L02.236	Carbuncle of umbilicus	ICD-10-CM	Diagnosis
L02.239	Carbuncle of trunk, unspecified	ICD-10-CM	Diagnosis
L02.31	Cutaneous abscess of buttock	ICD-10-CM	Diagnosis
L02.32	Furuncle of buttock	ICD-10-CM	Diagnosis
L02.33	Carbuncle of buttock	ICD-10-CM	Diagnosis
L02.411	Cutaneous abscess of right axilla	ICD-10-CM	Diagnosis
L02.412	Cutaneous abscess of left axilla	ICD-10-CM	Diagnosis
L02.413	Cutaneous abscess of right upper limb	ICD-10-CM	Diagnosis
L02.414	Cutaneous abscess of left upper limb	ICD-10-CM	Diagnosis
L02.415	Cutaneous abscess of right lower limb	ICD-10-CM	Diagnosis
L02.416	Cutaneous abscess of left lower limb	ICD-10-CM	Diagnosis
L02.419	Cutaneous abscess of limb, unspecified	ICD-10-CM	Diagnosis
L02.421	Furuncle of right axilla	ICD-10-CM	Diagnosis
L02.422	Furuncle of left axilla	ICD-10-CM	Diagnosis
L02.423	Furuncle of right upper limb	ICD-10-CM	Diagnosis
L02.424	Furuncle of left upper limb	ICD-10-CM	Diagnosis
L02.425	Furuncle of right lower limb	ICD-10-CM	Diagnosis
L02.426	Furuncle of left lower limb	ICD-10-CM	Diagnosis
L02.429	Furuncle of limb, unspecified	ICD-10-CM	Diagnosis
L02.431	Carbuncle of right axilla	ICD-10-CM	Diagnosis
L02.432	Carbuncle of left axilla	ICD-10-CM	Diagnosis
L02.433	Carbuncle of right upper limb	ICD-10-CM	Diagnosis
L02.434	Carbuncle of left upper limb	ICD-10-CM	Diagnosis
L02.435	Carbuncle of right lower limb	ICD-10-CM	Diagnosis
L02.436	Carbuncle of left lower limb	ICD-10-CM	Diagnosis
L02.439	Carbuncle of limb, unspecified	ICD-10-CM	Diagnosis
L02.511	Cutaneous abscess of right hand	ICD-10-CM	Diagnosis
L02.512	Cutaneous abscess of left hand	ICD-10-CM	Diagnosis
L02.519	Cutaneous abscess of unspecified hand	ICD-10-CM	Diagnosis
L02.521	Furuncle right hand	ICD-10-CM	Diagnosis
L02.522	Furuncle left hand	ICD-10-CM	Diagnosis
L02.529	Furuncle unspecified hand	ICD-10-CM	Diagnosis
L02.531	Carbuncle of right hand	ICD-10-CM	Diagnosis
L02.532	Carbuncle of left hand	ICD-10-CM	Diagnosis
L02.539	Carbuncle of unspecified hand	ICD-10-CM	Diagnosis
L02.611	Cutaneous abscess of right foot	ICD-10-CM	Diagnosis
L02.612	Cutaneous abscess of left foot	ICD-10-CM	Diagnosis
L02.619	Cutaneous abscess of unspecified foot	ICD-10-CM	Diagnosis
L02.621	Furuncle of right foot	ICD-10-CM	Diagnosis
L02.622	Furuncle of left foot	ICD-10-CM	Diagnosis
L02.629	Furuncle of unspecified foot	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
L02.631	Carbuncle of right foot	ICD-10-CM	Diagnosis
L02.632	Carbuncle of left foot	ICD-10-CM	Diagnosis
L02.639	Carbuncle of unspecified foot	ICD-10-CM	Diagnosis
L02.811	Cutaneous abscess of head [any part, except face]	ICD-10-CM	Diagnosis
L02.818	Cutaneous abscess of other sites	ICD-10-CM	Diagnosis
L02.821	Furuncle of head [any part, except face]	ICD-10-CM	Diagnosis
L02.828	Furuncle of other sites	ICD-10-CM	Diagnosis
L02.831	Carbuncle of head [any part, except face]	ICD-10-CM	Diagnosis
L02.838	Carbuncle of other sites	ICD-10-CM	Diagnosis
L02.91	Cutaneous abscess, unspecified	ICD-10-CM	Diagnosis
L02.92	Furuncle, unspecified	ICD-10-CM	Diagnosis
L02.93	Carbuncle, unspecified	ICD-10-CM	Diagnosis
L03.011	Cellulitis of right finger	ICD-10-CM	Diagnosis
L03.012	Cellulitis of left finger	ICD-10-CM	Diagnosis
L03.019	Cellulitis of unspecified finger	ICD-10-CM	Diagnosis
L03.031	Cellulitis of right toe	ICD-10-CM	Diagnosis
L03.032	Cellulitis of left toe	ICD-10-CM	Diagnosis
L03.039	Cellulitis of unspecified toe	ICD-10-CM	Diagnosis
L03.111	Cellulitis of right axilla	ICD-10-CM	Diagnosis
L03.112	Cellulitis of left axilla	ICD-10-CM	Diagnosis
L03.113	Cellulitis of right upper limb	ICD-10-CM	Diagnosis
L03.114	Cellulitis of left upper limb	ICD-10-CM	Diagnosis
L03.115	Cellulitis of right lower limb	ICD-10-CM	Diagnosis
L03.116	Cellulitis of left lower limb	ICD-10-CM	Diagnosis
L03.119	Cellulitis of unspecified part of limb	ICD-10-CM	Diagnosis
L03.211	Cellulitis of face	ICD-10-CM	Diagnosis
L03.213	Periorbital cellulitis	ICD-10-CM	Diagnosis
L03.221	Cellulitis of neck	ICD-10-CM	Diagnosis
L03.311	Cellulitis of abdominal wall	ICD-10-CM	Diagnosis
L03.312	Cellulitis of back [any part except buttock]	ICD-10-CM	Diagnosis
L03.313	Cellulitis of chest wall	ICD-10-CM	Diagnosis
L03.314	Cellulitis of groin	ICD-10-CM	Diagnosis
L03.315	Cellulitis of perineum	ICD-10-CM	Diagnosis
L03.316	Cellulitis of umbilicus	ICD-10-CM	Diagnosis
L03.317	Cellulitis of buttock	ICD-10-CM	Diagnosis
L03.319	Cellulitis of trunk, unspecified	ICD-10-CM	Diagnosis
L03.811	Cellulitis of head [any part, except face]	ICD-10-CM	Diagnosis
L03.818	Cellulitis of other sites	ICD-10-CM	Diagnosis
L03.90	Cellulitis, unspecified	ICD-10-CM	Diagnosis
L05.01	Pilonidal cyst with abscess	ICD-10-CM	Diagnosis
L05.02	Pilonidal sinus with abscess	ICD-10-CM	Diagnosis
L05.91	Pilonidal cyst without abscess	ICD-10-CM	Diagnosis
L05.92	Pilonidal sinus without abscess	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
L08.89	Other specified local infections of the skin and subcutaneous tissue	ICD-10-CM	Diagnosis
L08.9	Local infection of the skin and subcutaneous tissue, unspecified	ICD-10-CM	Diagnosis
M46.20	Osteomyelitis of vertebra, site unspecified	ICD-10-CM	Diagnosis
M46.21	Osteomyelitis of vertebra, occipito-atlanto-axial region	ICD-10-CM	Diagnosis
M46.22	Osteomyelitis of vertebra, cervical region	ICD-10-CM	Diagnosis
M46.23	Osteomyelitis of vertebra, cervicothoracic region	ICD-10-CM	Diagnosis
M46.24	Osteomyelitis of vertebra, thoracic region	ICD-10-CM	Diagnosis
M46.25	Osteomyelitis of vertebra, thoracolumbar region	ICD-10-CM	Diagnosis
M46.26	Osteomyelitis of vertebra, lumbar region	ICD-10-CM	Diagnosis
M46.27	Osteomyelitis of vertebra, lumbosacral region	ICD-10-CM	Diagnosis
M46.28	Osteomyelitis of vertebra, sacral and sacrococcygeal region	ICD-10-CM	Diagnosis
M72.6	Necrotizing fasciitis	ICD-10-CM	Diagnosis
M86.00	Acute hematogenous osteomyelitis, unspecified site	ICD-10-CM	Diagnosis
M86.011	Acute hematogenous osteomyelitis, right shoulder	ICD-10-CM	Diagnosis
M86.012	Acute hematogenous osteomyelitis, left shoulder	ICD-10-CM	Diagnosis
M86.019	Acute hematogenous osteomyelitis, unspecified shoulder	ICD-10-CM	Diagnosis
M86.021	Acute hematogenous osteomyelitis, right humerus	ICD-10-CM	Diagnosis
M86.022	Acute hematogenous osteomyelitis, left humerus	ICD-10-CM	Diagnosis
M86.029	Acute hematogenous osteomyelitis, unspecified humerus	ICD-10-CM	Diagnosis
M86.031	Acute hematogenous osteomyelitis, right radius and ulna	ICD-10-CM	Diagnosis
M86.032	Acute hematogenous osteomyelitis, left radius and ulna	ICD-10-CM	Diagnosis
M86.039	Acute hematogenous osteomyelitis, unspecified radius and ulna	ICD-10-CM	Diagnosis
M86.041	Acute hematogenous osteomyelitis, right hand	ICD-10-CM	Diagnosis
M86.042	Acute hematogenous osteomyelitis, left hand	ICD-10-CM	Diagnosis
M86.049	Acute hematogenous osteomyelitis, unspecified hand	ICD-10-CM	Diagnosis
M86.051	Acute hematogenous osteomyelitis, right femur	ICD-10-CM	Diagnosis
M86.052	Acute hematogenous osteomyelitis, left femur	ICD-10-CM	Diagnosis
M86.059	Acute hematogenous osteomyelitis, unspecified femur	ICD-10-CM	Diagnosis
M86.061	Acute hematogenous osteomyelitis, right tibia and fibula	ICD-10-CM	Diagnosis
M86.062	Acute hematogenous osteomyelitis, left tibia and fibula	ICD-10-CM	Diagnosis
M86.069	Acute hematogenous osteomyelitis, unspecified tibia and fibula	ICD-10-CM	Diagnosis
M86.071	Acute hematogenous osteomyelitis, right ankle and foot	ICD-10-CM	Diagnosis
M86.072	Acute hematogenous osteomyelitis, left ankle and foot	ICD-10-CM	Diagnosis
M86.079	Acute hematogenous osteomyelitis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M86.08	Acute hematogenous osteomyelitis, other sites	ICD-10-CM	Diagnosis
M86.09	Acute hematogenous osteomyelitis, multiple sites	ICD-10-CM	Diagnosis
M86.10	Other acute osteomyelitis, unspecified site	ICD-10-CM	Diagnosis
M86.111	Other acute osteomyelitis, right shoulder	ICD-10-CM	Diagnosis
M86.112	Other acute osteomyelitis, left shoulder	ICD-10-CM	Diagnosis
M86.119	Other acute osteomyelitis, unspecified shoulder	ICD-10-CM	Diagnosis

Appendix F. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes, Common Procedural Terminology, 4th Edition (CPT-4), Healthcare Common Procedure Coding System (HCPCS) Procedure Codes, and SOC Defined Lab Codes Used to Define Characteristics in this Request

Code	Description	Code Type	Code Category
M86.121	Other acute osteomyelitis, right humerus	ICD-10-CM	Diagnosis
M86.122	Other acute osteomyelitis, left humerus	ICD-10-CM	Diagnosis
M86.129	Other acute osteomyelitis, unspecified humerus	ICD-10-CM	Diagnosis
M86.131	Other acute osteomyelitis, right radius and ulna	ICD-10-CM	Diagnosis
M86.132	Other acute osteomyelitis, left radius and ulna	ICD-10-CM	Diagnosis
M86.139	Other acute osteomyelitis, unspecified radius and ulna	ICD-10-CM	Diagnosis
M86.141	Other acute osteomyelitis, right hand	ICD-10-CM	Diagnosis
M86.142	Other acute osteomyelitis, left hand	ICD-10-CM	Diagnosis
M86.149	Other acute osteomyelitis, unspecified hand	ICD-10-CM	Diagnosis
M86.151	Other acute osteomyelitis, right femur	ICD-10-CM	Diagnosis
M86.152	Other acute osteomyelitis, left femur	ICD-10-CM	Diagnosis
M86.159	Other acute osteomyelitis, unspecified femur	ICD-10-CM	Diagnosis
M86.161	Other acute osteomyelitis, right tibia and fibula	ICD-10-CM	Diagnosis
M86.162	Other acute osteomyelitis, left tibia and fibula	ICD-10-CM	Diagnosis
M86.169	Other acute osteomyelitis, unspecified tibia and fibula	ICD-10-CM	Diagnosis
M86.171	Other acute osteomyelitis, right ankle and foot	ICD-10-CM	Diagnosis
M86.172	Other acute osteomyelitis, left ankle and foot	ICD-10-CM	Diagnosis
M86.179	Other acute osteomyelitis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M86.18	Other acute osteomyelitis, other site	ICD-10-CM	Diagnosis
M86.19	Other acute osteomyelitis, multiple sites	ICD-10-CM	Diagnosis
M86.20	Subacute osteomyelitis, unspecified site	ICD-10-CM	Diagnosis
M86.211	Subacute osteomyelitis, right shoulder	ICD-10-CM	Diagnosis
M86.212	Subacute osteomyelitis, left shoulder	ICD-10-CM	Diagnosis
M86.219	Subacute osteomyelitis, unspecified shoulder	ICD-10-CM	Diagnosis
M86.221	Subacute osteomyelitis, right humerus	ICD-10-CM	Diagnosis
M86.222	Subacute osteomyelitis, left humerus	ICD-10-CM	Diagnosis
M86.229	Subacute osteomyelitis, unspecified humerus	ICD-10-CM	Diagnosis
M86.231	Subacute osteomyelitis, right radius and ulna	ICD-10-CM	Diagnosis
M86.232	Subacute osteomyelitis, left radius and ulna	ICD-10-CM	Diagnosis
M86.239	Subacute osteomyelitis, unspecified radius and ulna	ICD-10-CM	Diagnosis
M86.241	Subacute osteomyelitis, right hand	ICD-10-CM	Diagnosis
M86.242	Subacute osteomyelitis, left hand	ICD-10-CM	Diagnosis
M86.249	Subacute osteomyelitis, unspecified hand	ICD-10-CM	Diagnosis
M86.251	Subacute osteomyelitis, right femur	ICD-10-CM	Diagnosis
M86.252	Subacute osteomyelitis, left femur	ICD-10-CM	Diagnosis
M86.259	Subacute osteomyelitis, unspecified femur	ICD-10-CM	Diagnosis
M86.261	Subacute osteomyelitis, right tibia and fibula	ICD-10-CM	Diagnosis
M86.262	Subacute osteomyelitis, left tibia and fibula	ICD-10-CM	Diagnosis
M86.269	Subacute osteomyelitis, unspecified tibia and fibula	ICD-10-CM	Diagnosis
M86.271	Subacute osteomyelitis, right ankle and foot	ICD-10-CM	Diagnosis
M86.272	Subacute osteomyelitis, left ankle and foot	ICD-10-CM	Diagnosis
M86.279	Subacute osteomyelitis, unspecified ankle and foot	ICD-10-CM	Diagnosis
M86.28	Subacute osteomyelitis, other site	ICD-10-CM	Diagnosis
M86.29	Subacute osteomyelitis, multiple sites	ICD-10-CM	Diagnosis

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Code	Description	Code Type	Code Category
M86.8X0	Other osteomyelitis, multiple sites	ICD-10-CM	Diagnosis
M86.8X1	Other osteomyelitis, shoulder	ICD-10-CM	Diagnosis
M86.8X2	Other osteomyelitis, upper arm	ICD-10-CM	Diagnosis
M86.8X3	Other osteomyelitis, forearm	ICD-10-CM	Diagnosis
M86.8X4	Other osteomyelitis, hand	ICD-10-CM	Diagnosis
M86.8X5	Other osteomyelitis, thigh	ICD-10-CM	Diagnosis
M86.8X6	Other osteomyelitis, lower leg	ICD-10-CM	Diagnosis
M86.8X7	Other osteomyelitis, ankle and foot	ICD-10-CM	Diagnosis
M86.8X8	Other osteomyelitis, other site	ICD-10-CM	Diagnosis
M86.8X9	Other osteomyelitis, unspecified sites	ICD-10-CM	Diagnosis
M86.9	Osteomyelitis, unspecified	ICD-10-CM	Diagnosis
N10	Acute pyelonephritis	ICD-10-CM	Diagnosis
N16	Renal tubulo-interstitial disorders in diseases classified elsewhere	ICD-10-CM	Diagnosis
N48.21	Abscess of corpus cavernosum and penis	ICD-10-CM	Diagnosis
N48.22	Cellulitis of corpus cavernosum and penis	ICD-10-CM	Diagnosis
N61.1	Abscess of the breast and nipple	ICD-10-CM	Diagnosis
N73.0	Acute parametritis and pelvic cellulitis	ICD-10-CM	Diagnosis
N73.2	Unspecified parametritis and pelvic cellulitis	ICD-10-CM	Diagnosis
R65.20	Severe sepsis without septic shock	ICD-10-CM	Diagnosis
R65.21	Severe sepsis with septic shock	ICD-10-CM	Diagnosis
R78.81	Bacteremia	ICD-10-CM	Diagnosis
	Filgrastim Injections		
C9058	Injection, pegfilgrastim-bmez, biosimilar, (Ziextenzo) 0.5 mg	HCPCS	Procedure
C9096	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 mcg	HCPCS	Procedure
J1441	Injection, filgrastim (G-CSF), 480 mcg	HCPCS	Procedure
J1442	Injection, filgrastim (G-CSF), excludes biosimilars, 1 mcg	HCPCS	Procedure
J1446	Injection, TBO-filgrastim, 5 micrograms	HCPCS	Procedure
J1447	Injection, tbo-filgrastim, 1 mcg	HCPCS	Procedure
J2505	Injection, pegfilgrastim, 6 mg	HCPCS	Procedure
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	HCPCS	Procedure
Q5101	Injection, filgrastim-sndz, biosimilar, (Zarxio), 1 mcg	HCPCS	Procedure
Q5108	Injection, pegfilgrastim-jmdb (Fulphila), biosimilar, 0.5 mg	HCPCS	Procedure
Q5110	Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 mcg	HCPCS	Procedure
Q5111	Injection, pegfilgrastim-cbqv (Udenyca), biosimilar, 0.5 mg	HCPCS	Procedure
Q5120	Injection, pegfilgrastim-bmez (ZIEXTENZO), biosimilar, 0.5 mg	HCPCS	Procedure
Q5122	Injection, pegfilgrastim-apgf (Nyvepria), biosimilar, 0.5 mg	HCPCS	Procedure
Q5125	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 mcg	HCPCS	Procedure
Q5127	Injection, pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg	HCPCS	Procedure
Q5130	Injection, pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg	HCPCS	Procedure
	Absolute Neutrophil Count (ANC) Screenings		
L0032013010104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013010204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013010304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab

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Code	Description	Code Type	Code Category
L0032013010404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013010504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013020104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013020204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013020304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013020404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013020504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013070104	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013070204	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013070304	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013070404	ANC Lab (K/UL)	SOC Defined Quantitative	Lab
L0032013070504	ANC Lab (K/UL)	SOC Defined Quantitative	Lab

Appendix G. Specifications Defining Parameters for this Request: cder_mpl1r_wp284 (All 13 Data Partners)

This request executed the Cohort Identification and Descriptive Analysis (CIDA) tool version 13.1.2 to describe clozapine users and treatment episodes in the Sentinel Distributed Database (SDD).

Query period: January 1, 2010- Most Recent Available Data (January 1, 2024)
Coverage requirement: Medical & Drug Coverage
Pre-index enrollment requirement: See Scenarios
Post-index requirement: N/A[1]
Post-episode requirement for Type 2 analyses: N/A
Enrollment gap: 45 days
Age groups: 12-18, 19-35, 36-50, 51-64, 65-75, 75+ years
Stratifications: N/A
Censor output categorization: N/A
Restrictions: Female and Male
Envelope macro: No reclassification on inpatient Adate
Distribution of index-defining codes: N/A
Never-exposed cohort: N/A
Freeze data: No

	Exposure								
Scenario	Index Exposure	Cohort Definition	Pre-Index Enrollment	Incident Exposure Washout Period	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Build Episodes on Point Exposure?	Treatment Episode Gap Type	Treatment Episode Gap	Exposure Episode Extension Period
1	Clozapine	02: Cohort includes all valid exposure episodes during the query period	183	**30**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days	30 Days

Appendix G. Specifications Defining Parameters for this Request: cder_mpl1r_wp284 (All 13 Data Partners)									
	Exposure								
Scenario	Index Exposure	Cohort Definition	Pre-Index Enrollment	Incident Exposure Washout Period	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Build Episodes on Point Exposure?	Treatment Episode Gap Type	Treatment Episode Gap	Exposure Episode Extension Period
2	Clozapine	01: Cohort includes only the first valid exposure episode during the query period	183	**30**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days	30 Days
3	Clozapine	02: Cohort includes all valid exposure episodes during the query period	183	**183**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days	30 Days
4	Clozapine	01: Cohort includes only the first valid exposure episode during the query period	183	**183**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days	30 Days

Appendix G. Specifications Defining Parameters for this Request: cder_mpl1r_wp284 (All 13 Data Partners)								
	Exposure							
Scenario	Minimum Exposure Episode Duration	Minimum Exposure Episode Days Supplied	Maximum Exposure Episode Duration	Care setting	Principal diagnosis position	Forced Supply to Attach to Dispensings	Create Baseline Table?	End At-Risk Period at Evidence of
1	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)
2	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)
3	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)

Appendix G. Specifications Defining Parameters for this Request: cder_mpl1r_wp284 (All 13 Data Partners)								
	Exposure							
Scenario	Minimum Exposure Episode Duration	Minimum Exposure Episode Days Supplied	Maximum Exposure Episode Duration	Care setting	Principal diagnosis position	Forced Supply to Attach to Dispensings	Create Baseline Table?	End At-Risk Period at Evidence of
4	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)

[1]N/A: Not Applicable

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)

This request executed the Cohort Identification and Descriptive Analysis (CIDA) tool version 13.1.2 with plus programming to estimate rates of clozapine, evidence of monitoring and neutropenia in the Sentinel Distributed Database (SDD).

Query period: January 1, 2010- Most Recent Available Data (January 1, 2024)
Coverage requirement: Medical & Drug Coverage
Pre-index enrollment requirement: See Scenarios
Post-index requirement: N/A[1]
Post-episode requirement for Type 2 analyses: N/A
Enrollment gap: 45 days
Age groups: 12-18, 19-35, 36-50, 51-64, 65-75, 75+ years
Stratifications: Occurrence of absolute neutrophil count (ANC[2]) screenings prior to the outcome of interest
Censor output categorization: N/A
Restrictions: Female and Male
Envelope macro: No reclassification on inpatient Adate
Distribution of index-defining codes: N/A
Never-exposed cohort: N/A
Freeze data: No

	Exposure							
Scenario	Index Exposure	Cohort Definition	Pre-Index Enrollment	Incident Exposure Washout Period	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Build Episodes on Point Exposure?	Treatment Episode Gap Type	Treatment Episode Gap
1	Clozapine	02: Cohort includes all valid exposure episodes during the query period	183	**30**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**No**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)								
	Exposure							
Scenario	Index Exposure	Cohort Definition	Pre-Index Enrollment	Incident Exposure Washout Period	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Build Episodes on Point Exposure?	Treatment Episode Gap Type	Treatment Episode Gap
2	Clozapine	01: Cohort includes only the first valid exposure episode during the query period	183	**30**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days
3	Clozapine	02: Cohort includes all valid exposure episodes during the query period	183	**30**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days
4	Clozapine	02: Cohort includes all valid exposure episodes during the query period	183	**30**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days
5	Clozapine	01: Cohort includes only the first valid exposure episode during the query period	183	**30**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)								
	Exposure							
Scenario	Index Exposure	Cohort Definition	Pre-Index Enrollment	Incident Exposure Washout Period	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Build Episodes on Point Exposure?	Treatment Episode Gap Type	Treatment Episode Gap
6	Clozapine	01: Cohort includes only the first valid exposure episode during the query period	183	**30**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days
7	Clozapine	02: Cohort includes all valid exposure episodes during the query period	183	**183**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days
8	Clozapine	01: Cohort includes only the first valid exposure episode during the query period	183	**183**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days
9	Clozapine	02: Cohort includes all valid exposure episodes during the query period	183	**183**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)								
	Exposure							
Scenario	Index Exposure	Cohort Definition	Pre-Index Enrollment	Incident Exposure Washout Period	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Build Episodes on Point Exposure?	Treatment Episode Gap Type	Treatment Episode Gap
10	Clozapine	02: Cohort includes all valid exposure episodes during the query period	183	**183**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days
11	Clozapine	01: Cohort includes only the first valid exposure episode during the query period	183	**183**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days
12	Clozapine	01: Cohort includes only the first valid exposure episode during the query period	183	**183**	**N:** Lookback period should search for evidence of a date or an interval *(DATEONLY)*	**N**	**F:** Fixed episode gap. The value specified in EPISODEGAP will be used to determine if two consecutive claims are in the same episode.	30 Days

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)									
	Exposure								
Scenario	Exposure Episode Extension Period	Minimum Exposure Episode Duration	Minimum Exposure Episode Days Supplied	Maximum Exposure Episode Duration	Care setting	Principal diagnosis position	Forced Supply to Attach to Dispensings	Create Baseline Table?	End At-Risk Period at Evidence of
1	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)
2	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)									
	Exposure								
Scenario	Exposure Episode Extension Period	Minimum Exposure Episode Duration	Minimum Exposure Episode Days Supplied	Maximum Exposure Episode Duration	Care setting	Principal diagnosis position	Forced Supply to Attach to Dispensings	Create Baseline Table?	End At-Risk Period at Evidence of
3	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)
4	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)
5	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**N**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)									
	Exposure								
Scenario	Exposure Episode Extension Period	Minimum Exposure Episode Duration	Minimum Exposure Episode Days Supplied	Maximum Exposure Episode Duration	Care setting	Principal diagnosis position	Forced Supply to Attach to Dispensings	Create Baseline Table?	End At-Risk Period at Evidence of
6	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**N**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)
7	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)
8	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)

	Exposure								
Scenario	Exposure Episode Extension Period	Minimum Exposure Episode Duration	Minimum Exposure Episode Days Supplied	Maximum Exposure Episode Duration	Care setting	Principal diagnosis position	Forced Supply to Attach to Dispensings	Create Baseline Table?	End At-Risk Period at Evidence of
9	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)
10	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**Y**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)
11	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**N**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)									
	Exposure								
Scenario	Exposure Episode Extension Period	Minimum Exposure Episode Duration	Minimum Exposure Episode Days Supplied	Maximum Exposure Episode Duration	Care setting	Principal diagnosis position	Forced Supply to Attach to Dispensings	Create Baseline Table?	End At-Risk Period at Evidence of
12	30 Days	1 day	1 day	183	**N/A**	*N/A*	N/A	**N**	*Death (CENSOR_DTH) *DP end date (QRP will automatically censor for this) *Query end date (INEDENDATE and/or INDENDOPTIONS) *Occurence of an exposure or event (INDEXCRITERIA and/or FUPCRITERIA)

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)										
	Inclusion/Exclusion Criteria									
Scenario	Inclusion/ Exclusion Group	Criteria	Care Setting	Principal Diagnosis Position	Evaluation Period Start	Evaluation Period End	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Number of Instances for the Condition	Minimum Days Supplied	Forced Supply to Attach to Dispensings
1	N/A	N/A	*N/A*	*N/A*	N/A	N/A	N/A	N/A	N/A	N/A
2	N/A	N/A	*N/A*	*N/A*	N/A	N/A	N/A	N/A	N/A	N/A
3	80% Correspondence	Inclusion	**N/A**	*N/A*	0	0	**N/A**	1	N/A	N/A
4	100% Correspondence	Inclusion	**N/A**	*N/A*	0	0	**N/A**	1	N/A	N/A
5	80% Correspondence	Inclusion	**N/A**	*N/A*	0	0	**N/A**	1	N/A	N/A

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)										
	Inclusion/Exclusion Criteria									
Scenario	Inclusion/ Exclusion Group	Criteria	Care Setting	Principal Diagnosis Position	Evaluation Period Start	Evaluation Period End	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Number of Instances for the Condition	Minimum Days Supplied	Forced Supply to Attach to Dispensings
6	100% Correspondence	Inclusion	**N/A**	*N/A*	0	0	**N/A**	1	N/A	N/A
7	N/A	N/A	*N/A*	*N/A*	N/A	N/A	N/A	N/A	N/A	N/A
8	N/A	N/A	*N/A*	*N/A*	N/A	N/A	N/A	N/A	N/A	N/A
9	80% Correspondence	Inclusion	**N/A**	*N/A*	0	0	**N/A**	1	N/A	N/A
10	100% Correspondence	Inclusion	**N/A**	*N/A*	0	0	**N/A**	1	N/A	N/A

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)										
	Inclusion/Exclusion Criteria									
Scenario	Inclusion/ Exclusion Group	Criteria	Care Setting	Principal Diagnosis Position	Evaluation Period Start	Evaluation Period End	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Number of Instances for the Condition	Minimum Days Supplied	Forced Supply to Attach to Dispensings
11	80% Correspondence	Inclusion	**N/A**	*N/A*	0	0	**N/A**	1	N/A	N/A
12	100% Correspondence	Inclusion	**N/A**	*N/A*	0	0	**N/A**	1	N/A	N/A

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)						
	Health Outcomes of Interest (HOI)					
Scenario	Event	HOI Washout Period	Care setting	Principal diagnosis position	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Event De-Duplication
1	N/A	N/A	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A	N/A	N/A
3	No Outcome or Any Outcome or Severe Neutropenia DX or Severe Neutropenia Lab or Severe Neutropenia DX or Mutually Exclusive Moderate Neutropenia or Moderate Neutropenia or Mutually Exclusive Mild Neutropenia or Mild Neutropenia	0	**IP:** inpatient hospital stays **IS:** non-acute institutional stays **ED:** emergency department encounters **AV:** ambulatory visits	Any	N/A	**2:** de-duplicates occurrences of the same HOI GROUP on the same day (e.g., de-duplicates at the GROUP level).

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)						
	Health Outcomes of Interest (HOI)					
Scenario	Event	HOI Washout Period	Care setting	Principal diagnosis position	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Event De-Duplication
4	No Outcome or Any Outcome or Severe Neutropenia DX or Severe Neutropenia Lab or Severe Neutropenia DX or Mutually Exclusive Moderate Neutropenia or Moderate Neutropenia or Mutually Exclusive Mild Neutropenia or Mild Neutropenia	0	**IP:** inpatient hospital stays **IS:** non-acute institutional stays **ED:** emergency department encounters **AV:** ambulatory visits	Any	N/A	**2:** de-duplicates occurrences of the same HOI GROUP on the same day (e.g., de-duplicates at the GROUP level).
5	No Outcome or Any Outcome or Severe Neutropenia DX or Severe Neutropenia Lab or Severe Neutropenia DX or Mutually Exclusive Moderate Neutropenia or Moderate Neutropenia or Mutually Exclusive Mild Neutropenia or Mild Neutropenia	0	**IP:** inpatient hospital stays **IS:** non-acute institutional stays **ED:** emergency department encounters **AV:** ambulatory visits	Any	N/A	**2:** de-duplicates occurrences of the same HOI GROUP on the same day (e.g., de-duplicates at the GROUP level).

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)						
	Health Outcomes of Interest (HOI)					
Scenario	Event	HOI Washout Period	Care setting	Principal diagnosis position	Exclude Evidence of Days Supply if Event Washout Includes Dispensings	Event De-Duplication
6	No Outcome or Any Outcome or Severe Neutropenia DX or Severe Neutropenia Lab or Severe Neutropenia DX or Mutually Exclusive Moderate Neutropenia or Moderate Neutropenia or Mutually Exclusive Mild Neutropenia or Mild Neutropenia	0	**IP:** inpatient hospital stays **IS:** non-acute institutional stays **ED:** emergency department encounters **AV:** ambulatory visits	Any	N/A	**2:** de-duplicates occurrences of the same HOI GROUP on the same day (e.g., de-duplicates at the GROUP level).
7	N/A	N/A	N/A	N/A	N/A	N/A
8	N/A	N/A	N/A	N/A	N/A	N/A
9	No Outcome or Any Outcome or Severe Neutropenia DX or Severe Neutropenia Lab or Severe Neutropenia DX or Mutually Exclusive Moderate Neutropenia or Moderate Neutropenia or Mutually Exclusive Mild Neutropenia or Mild Neutropenia	0	**IP:** inpatient hospital stays **IS:** non-acute institutional stays **ED:** emergency department encounters **AV:** ambulatory visits	Any	N/A	**2:** de-duplicates occurrences of the same HOI GROUP on the same day (e.g., de-duplicates at the GROUP level).

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)

	Health Outcomes of Interest (HOI)					
Scenario	**Event**	**HOI Washout Period**	**Care setting**	**Principal diagnosis position**	**Exclude Evidence of Days Supply if Event Washout Includes Dispensings**	**Event De-Duplication**
10	No Outcome or Any Outcome or Severe Neutropenia DX or Severe Neutropenia Lab or Severe Neutropenia DX or Mutually Exclusive Moderate Neutropenia or Moderate Neutropenia or Mutually Exclusive Mild Neutropenia or Mild Neutropenia	0	**IP:** inpatient hospital stays **IS:** non-acute institutional stays **ED:** emergency department encounters **AV:** ambulatory visits	Any	N/A	**2:** de-duplicates occurrences of the same HOI GROUP on the same day (e.g., de-duplicates at the GROUP level).
11	No Outcome or Any Outcome or Severe Neutropenia DX or Severe Neutropenia Lab or Severe Neutropenia DX or Mutually Exclusive Moderate Neutropenia or Moderate Neutropenia or Mutually Exclusive Mild Neutropenia or Mild Neutropenia	0	**IP:** inpatient hospital stays **IS:** non-acute institutional stays **ED:** emergency department encounters **AV:** ambulatory visits	Any	N/A	**2:** de-duplicates occurrences of the same HOI GROUP on the same day (e.g., de-duplicates at the GROUP level).

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)						
	Health Outcomes of Interest (HOI)					
Scenario	**Event**	**HOI Washout Period**	**Care setting**	**Principal diagnosis position**	**Exclude Evidence of Days Supply if Event Washout Includes Dispensings**	**Event De-Duplication**
12	No Outcome or Any Outcome or Severe Neutropenia DX or Severe Neutropenia Lab or Severe Neutropenia DX or Mutually Exclusive Moderate Neutropenia or Moderate Neutropenia or Mutually Exclusive Mild Neutropenia or Mild Neutropenia	0	**IP:** inpatient hospital stays **IS:** non-acute institutional stays **ED:** emergency department encounters **AV:** ambulatory visits	Any	N/A	**2:** de-duplicates occurrences of the same HOI GROUP on the same day (e.g., de-duplicates at the GROUP level).

Appendix H. Specifications Defining Parameters for this Request: cder_mpl1p_wp094 (Only 8 Data Partners)

	Health Outcomes of Interest (HOI)		
Scenario	**Forced Supply to Attach to Dispensings**	**Blackout Period**	**Risk Window Interval Start**
1	N/A	N/A	N/A
2	N/A	N/A	N/A
3	N/A	.	1
4	N/A	.	1
5	N/A	.	1
6	N/A	.	1
7	N/A	N/A	N/A
8	N/A	N/A	N/A
9	N/A	.	1
10	N/A	.	1
11	N/A	.	1
12	N/A	.	1

[1]N/A: Not Applicable

[2]ANC: Absolute neutrophil count

Appendix I. Specifications Defining Baseline Characteristics for both Requests

Covariate Name	Covariate Number	Code Category	Care Setting	Principal Diagnosis Position	Covariate Evaluation Period Start	Covariate Evaluation Period End
Absolute Neutrophil Count (ANC[1]) Screening Days -7 to -1	1	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-7 in relation to Outcome	-1 in relation to Outcome
ANC Screening Days -14 to -1	2	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-14 in relation to Outcome	-1 in relation to Outcome
ANC Screening Days -30 to -1	3	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-30 in relation to Outcome	-1 in relation to Outcome
Chemotherapy	4	R**X:**Drug Codes **PX:** Procedure Codes	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-30 in relation to Outcome	-1 in relation to Outcome
Inpatient Serious Infection Diagnosis	5	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	Any	Day of Outcome (0)	30 in relation to Outcome
Inpatient Serious Infection Diagnosis	6	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	Any	-30 in relation to Outcome	-1 in relation to Outcome
Antimicrobial Dispensing	7	P**X:** Procedure code **NDC:**Drug Code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	Any	Day of Outcome (0)	30 in relation to Outcome
Filgrastim injections	8	**PX:** Procedure code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	Any	Day of Outcome (0)	30 in relation to Outcome

Appendix I. Specifications Defining Baseline Characteristics for both Requests

Covariate Name	Covariate Number	Code Category	Care Setting	Principal Diagnosis Position	Covariate Evaluation Period Start	Covariate Evaluation Period End
Anxiety	9	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Bipolar Disorder	10	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Cardiovascular Disorder	11	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Chronic Kidney Disease	12	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Chronic Obstructive Pulmonary Disease (COPD)	13	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Depressive Disorder	14	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Diabetes	15	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Post-Traumatic Stress Disorder (PTSD)	16	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1

Appendix I. Specifications Defining Baseline Characteristics for both Requests

Covariate Name	Covariate Number	Code Category	Care Setting	Principal Diagnosis Position	Covariate Evaluation Period Start	Covariate Evaluation Period End
Schizophrenia and Schizoaffective disorder	17	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Substance Use Disorder	18	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Crohn's Disease	19	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Rheumatoid Arthritis	20	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Chronic Immune Hepatitis	21	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1
Systematic Lupus Erythematosus	22	**DX:** Diagnosis code	**Blank**: Any caresetting *(CARESETTINGPRINCIPAL)*	*Any*	-183	-1

Appendix I. Specifications Defining Baseline Characteristics for both Requests

Covariate Name	Covariate Number	Number of Instances the Covariate Should be Found in Evaluation Period	Forced Supply to Attach to a Code *(only applies to RX codes)*	Lookback Period Date Only	Lab Date Selection Algorithm	Lab Result Values
ANC Screening Days -7 to -1	1	1	N/A[2]	**N/A**	N/A	N/A
ANC Screening Days -14 to -1	2	1	N/A	**N/A**	N/A	N/A
ANC Screening Days -30 to -1	3	1	N/A	**N/A**	N/A	N/A
Chemotherapy	4	1	N/A	**N/A**	N/A	N/A
Inpatient Serious Infection Diagnosis	5	1	N/A	**N/A**	N/A	N/A
Inpatient Serious Infection Diagnosis	6	1	N/A	**N/A**	N/A	N/A

Appendix I. Specifications Defining Baseline Characteristics for both Requests

Covariate Name	Covariate Number	Number of Instances the Covariate Should be Found in Evaluation Period	Forced Supply to Attach to a Code *(only applies to RX codes)*	Lookback Period Date Only	Lab Date Selection Algorithm	Lab Result Values
Antimicrobial Dispensing	7	1	N/A	**N/A**	N/A	N/A
Filgrastim injections	8	1	N/A	**N/A**	N/A	N/A
Anxiety	9	1	N/A	**N/A**	N/A	N/A
Bipolar Disorder	10	1	N/A	**N/A**	N/A	N/A
Cardiovascular Disorder	11	1	N/A	**N/A**	N/A	N/A
Chronic Kidney Disease	12	1	N/A	**N/A**	N/A	N/A

Appendix I. Specifications Defining Baseline Characteristics for both Requests

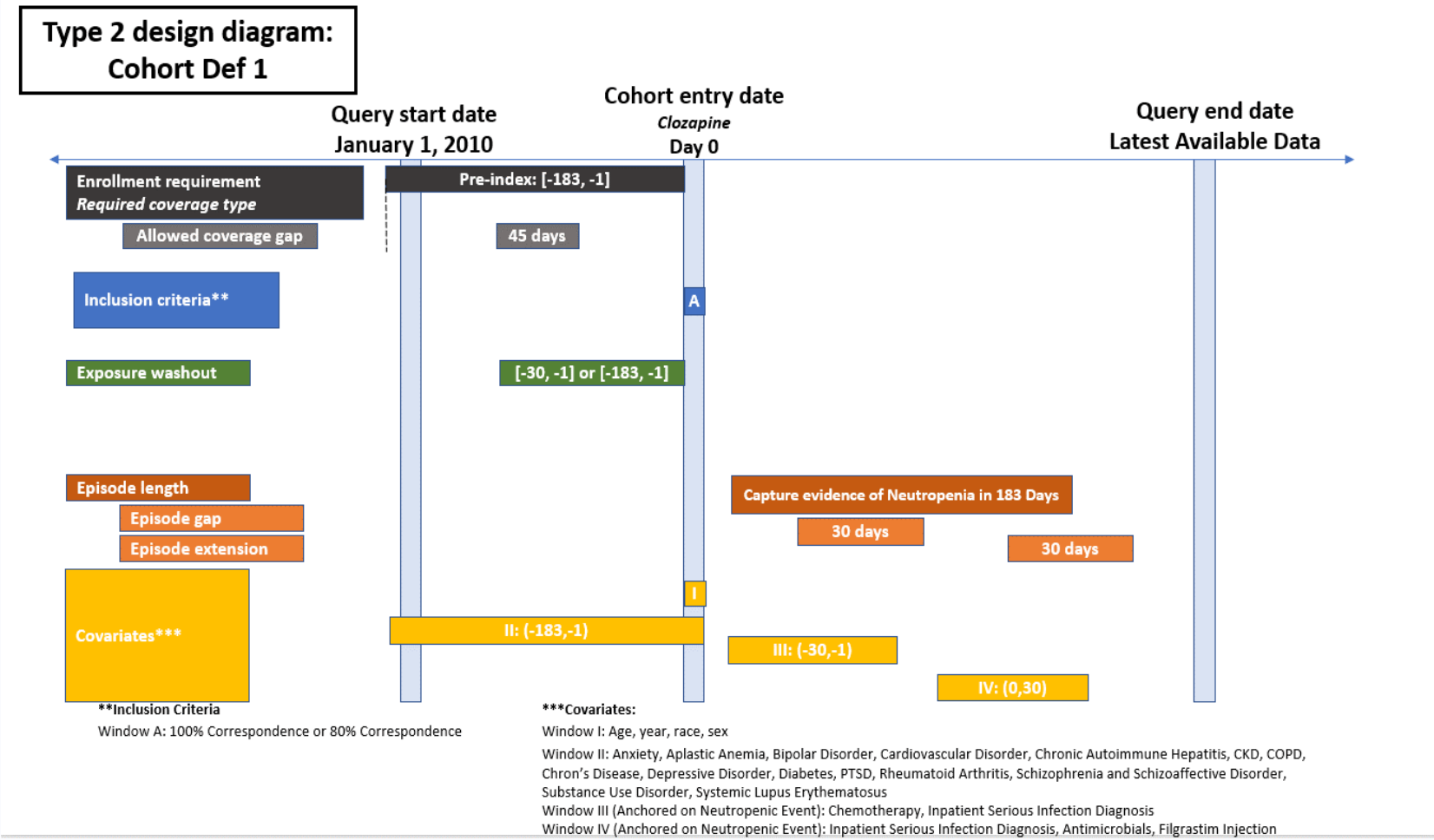
Covariate Name	Covariate Number	Number of Instances the Covariate Should be Found in Evaluation Period	Forced Supply to Attach to a Code *(only applies to RX codes)*	Lookback Period Date Only	Lab Date Selection Algorithm	Lab Result Values
COPD	13	1	N/A	**N/A**	N/A	N/A
Depressive Disorder	14	1	N/A	**N/A**	N/A	N/A
Diabetes	15	1	N/A	**N/A**	N/A	N/A
PTSD	16	1	N/A	**N/A**	N/A	N/A
Schizophrenia and Schizoaffective disorder	17	1	N/A	**N/A**	N/A	N/A
Substance Use Disorder	18	1	N/A	**N/A**	N/A	N/A

Appendix I. Specifications Defining Baseline Characteristics for both Requests

Covariate Name	Covariate Number	Number of Instances the Covariate Should be Found in Evaluation Period	Forced Supply to Attach to a Code *(only applies to RX codes)*	Lookback Period Date Only	Lab Date Selection Algorithm	Lab Result Values
Crohn's Disease	19	1	N/A	**N/A**	N/A	N/A
Rheumatoid Arthritis	20	1	N/A	**N/A**	N/A	N/A
Chronic Immune Hepatitis	21	1	N/A	**N/A**	N/A	N/A
Systematic Lupus Erythematosus	22	1	N/A	**N/A**	N/A	N/A

[1]ANC: Absolute neutrophil count
[2]N/A: Not Applicable

Appendix J. Design Diagrams of Cohort Entry Requirements, Index Exposure, and Event Outcome Assessment for both Requests



Appendix J. Design Diagrams of Cohort Entry Requirements, Index Exposure, and Event Outcome Assessment for both Requests