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).

If you are using a web page screen reader and are unable to access this document, please contact the Sentinel Operations Center for assistance at info@sentinelsystem.org.
Date Run: June 5, 2017

Request Description: The purpose of this report was to compare the frequency of diagnoses for gastrointestinal bleeding using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) versus International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes. ICD-10-CM code definitions were determined from an algorithm and by mapping from ICD-9-CM code definitions using the Centers for Medicare and Medicaid Services (CMS) General Equivalence Mappings (GEMs). Forward-backward mapping (FBM) was used to map ICD-9-CM to ICD-10-CM codes.¹

Sentinel Routine Querying Module: Cohort Identification and Descriptive Analysis (CIDA) module, version 3.3.6

Data Source: This request was run against the IBM® MarketScan® Commercial Claims and Encounters Database and Medicare Supplemental Database, which included 121 million members. Data from October 1, 2010 to March 31, 2016 were included in this report. The report includes three separate time periods: 1) October 1, 2010 to March 31, 2016; 2) January 1, 2015 to March 31, 2015; and 3) January 1, 2016 to March 31, 2016. See Appendix A for the dates of available data used in this report.

Study Design: We examined the incidence of gastrointestinal bleeding across the ICD-9-CM era (October 2010 - September 2015) and ICD-10-CM era (October 2015 - June 2016), and additionally from January 2015 to March 2015, and from January 2016 to March 2016 in the United States See Appendix B for specific codes used to define gastrointestinal bleeding in this request.

Cohort Eligibility Criteria: Members included in the cohort were required to be continuously enrolled in health plans with medical coverage for at least six months (183 days) before their diagnosis date, during which gaps in coverage of up to 45 days were allowed. Incident gastrointestinal bleeding was defined as no previous gastrointestinal bleeding diagnosis in the 183 days preceding the index date with respect to ICD-9-CM and ICD-10-CM codes. The following age groups were included in the cohort: 0-17, 18-49, 50-64, and 65+ years.

Please see Appendix C for detailed specifications of parameters used in the analyses for this request.

Limitations: Algorithms used to define outcomes are imperfect; thus, it is possible that there may be misclassification. Therefore, data should be interpreted with this limitation in mind. The MarketScan claims databases are based on a large convenience sample. Because the sample is not random, it may contain biases or fail to generalize well to other populations. Data come mostly from large employers; medium and small firms may be underrepresented.²

Notes: Please contact the Sentinel Operations Center (info@sentinelssystem.org) for questions and to provide comments/suggestions for future enhancements to this document.

Table of Contents

**Glossary**  List of Terms Found in this Report and their Definitions

**Table 1**  Comparison of Incident Gastrointestinal Bleeding Diagnoses in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Eras (January 1, 2015 - March 31, 2015 and January 1, 2016 - March 31, 2016)

**Figure 1**  Incidence of Gastrointestinal Bleeding Diagnoses per 10,000 Eligible Members from October 2010 - March 2016 by Code Type, 183-Day Washout

**Appendix A**  Dates Available for IBM® MarketScan® Commercial and Medicare Supplemental Databases

**Appendix B**  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) Codes Used to Define Gastrointestinal Bleeding

**Appendix C**  Specifications for Parameters for this Request
Glossary of Terms for Analyses Using
Cohort Identification and Descriptive Analysis (CIDA) Tool*

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, 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.

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.

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 MP algorithm: 0: Counts all occurrences of an 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 days are added after any episode gaps have been bridged.

Lookback Period - number of days wherein a member is required to have evidence of pre-existing condition (diagnosis/procedure/drug dispensing).
Maximum Episode Duration - truncates exposure episodes after a requester-specified number of exposed days. Applied after any gaps are bridged and extension days added to the length of the exposure episode.

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

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

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

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

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

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

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 1. Comparison of Incident* Gastrointestinal Bleeding Diagnoses in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Eras (January 1, 2015 - March 31, 2015 and January 1, 2016 - March 31, 2016)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Members with Diagnosis</th>
<th>Eligible Members</th>
<th>Members with Diagnosis per 10,000 Eligible Members</th>
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</thead>
<tbody>
<tr>
<td>Gastrointestinal Bleeding</td>
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<tr>
<td>ICD-10-CM: Algorithm: January 1, 2016 - March 31, 2016</td>
<td>3,288</td>
<td>22,690,741</td>
<td>1.44</td>
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<tr>
<td>ICD-10-CM: Forward-Backward Mapping: January 1, 2016 - March 31, 2016</td>
<td>4,942</td>
<td>22,689,258</td>
<td>2.18</td>
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</tbody>
</table>

*Incidence defined by a 90 day washout
Figure 1. Incidence of Gastrointestinal Bleeding Diagnoses per 10,000 Eligible Members from October 2010 - March 2016 by Code Type, 183-Day Washout
Appendix A. Dates Available for IBM® MarketScan® Commercial and Medicare Supplemental Databases

<table>
<thead>
<tr>
<th>Databases</th>
<th>Start Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>IBM MarketScan Commercial and Medicare Supplemental Databases¹</td>
<td>1/1/2010</td>
<td>3/31/2016</td>
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</tbody>
</table>

¹ The IBM MarketScan Databases includes a sample of 121 million employees, dependents, and retirees in the United States with primary or Medicare supplemental coverage through privately insured fee-for-service, point-of-service, or capitated health plans. The IBM MarketScan claims databases are based on a large convenience sample. Because the sample is not random, it may contain biases or fail to generalize well to other populations. Data come mostly from large employers; medium and small firms may be underrepresented. For more information on the IBM MarketScan Databases, please review the White Paper here: https://www.ibm.com/downloads/cas/OWZWJ0QO
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<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code Type</th>
</tr>
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<tbody>
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<td>ICD-9-CM</td>
</tr>
<tr>
<td>531.00</td>
<td>Acute gastric ulcer with hemorrhage, without mention of obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>531.01</td>
<td>Acute gastric ulcer with hemorrhage and obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>531.20</td>
<td>Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>531.21</td>
<td>Acute gastric ulcer with hemorrhage, perforation, and obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>531.40</td>
<td>Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>531.41</td>
<td>Chronic or unspecified gastric ulcer with hemorrhage and obstruction</td>
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<td>531.60</td>
<td>Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>531.61</td>
<td>Chronic or unspecified gastric ulcer with hemorrhage, perforation, and obstruction</td>
<td>ICD-9-CM</td>
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<tr>
<td>532.00</td>
<td>Acute duodenal ulcer with hemorrhage, without mention of obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>532.01</td>
<td>Acute duodenal ulcer with hemorrhage and obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>532.20</td>
<td>Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>532.21</td>
<td>Acute duodenal ulcer with hemorrhage, perforation, and obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>532.40</td>
<td>Duodenal ulcer, chronic or unspecified, with hemorrhage, without mention of obstruction</td>
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</tr>
<tr>
<td>532.41</td>
<td>Chronic or unspecified duodenal ulcer with hemorrhage and obstruction</td>
<td>ICD-9-CM</td>
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<tr>
<td>532.60</td>
<td>Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction</td>
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<tr>
<td>532.61</td>
<td>Chronic or unspecified duodenal ulcer with hemorrhage, perforation, and obstruction</td>
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<tr>
<td>533.00</td>
<td>Acute peptic ulcer, unspecified site, with hemorrhage, without mention of obstruction</td>
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<tr>
<td>533.01</td>
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<tr>
<td>533.20</td>
<td>Acute peptic ulcer, unspecified site, with hemorrhage and perforation, without mention of obstruction</td>
<td>ICD-9-CM</td>
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<tr>
<td>533.21</td>
<td>Acute peptic ulcer, unspecified site, with hemorrhage, perforation, and obstruction</td>
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<tr>
<td>533.40</td>
<td>Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage, without mention of obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>533.41</td>
<td>Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage and obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>533.60</td>
<td>Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage and perforation, without mention of obstruction</td>
<td>ICD-9-CM</td>
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<tr>
<td>533.61</td>
<td>Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage, perforation, and obstruction</td>
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<tr>
<td>534.00</td>
<td>Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction</td>
<td>ICD-9-CM</td>
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<tr>
<td>534.01</td>
<td>Acute gastrojejunal ulcer, with hemorrhage and obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>534.20</td>
<td>Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>534.21</td>
<td>Acute gastrojejunal ulcer with hemorrhage, perforation, and obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>534.40</td>
<td>Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>534.41</td>
<td>Chronic or unspecified gastrojejunal ulcer, with hemorrhage and obstruction</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>534.60</td>
<td>Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction</td>
<td>ICD-9-CM</td>
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<tr>
<td>534.61</td>
<td>Chronic or unspecified gastrojejunal ulcer with hemorrhage, perforation, and obstruction</td>
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<tr>
<td>535.01</td>
<td>Acute gastritis with hemorrhage</td>
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<tr>
<td>535.11</td>
<td>Atrophic gastritis with hemorrhage</td>
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<tr>
<td>535.21</td>
<td>Gastric mucosal hypertrophy with hemorrhage</td>
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<tr>
<td>535.31</td>
<td>Alcoholic gastritis with hemorrhage</td>
<td>ICD-9-CM</td>
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Appendix B. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Gastrointestinal Bleeding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>535.41</td>
<td>Other specified gastritis with hemorrhage</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>535.51</td>
<td>Unspecified gastritis and gastroduodenitis with hemorrhage</td>
<td>ICD-9-CM</td>
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<tr>
<td>535.61</td>
<td>Duodenitis with hemorrhage</td>
<td>ICD-9-CM</td>
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<td>537.83</td>
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<td>562.02</td>
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**ICD-10-CM (Algorithm)**

<table>
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<th>Description</th>
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<tr>
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<td>K25.0</td>
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<td>K25.6</td>
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<td>K26.2</td>
<td>Acute duodenal ulcer with both hemorrhage and perforation</td>
<td>ICD-10-CM</td>
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<td>K26.4</td>
<td>Chronic or unspecified duodenal ulcer with hemorrhage</td>
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<td>Chronic or unspecified duodenal ulcer with both hemorrhage and perforation</td>
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<td>Chronic or unspecified peptic ulcer, site unspecified, with hemorrhage</td>
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<td>Other gastritis with bleeding</td>
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<tr>
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<td>K57.11</td>
<td>Diverticulosis of small intestine without perforation or abscess with bleeding</td>
<td>ICD-10-CM</td>
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</table>
Appendix B. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Gastrointestinal Bleeding

<table>
<thead>
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<th>Code</th>
<th>Description</th>
<th>Code Type</th>
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<tbody>
<tr>
<td>K57.13</td>
<td>Diverticulitis of small intestine without perforation or abscess with bleeding</td>
<td>ICD-10-CM</td>
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<tr>
<td>K57.31</td>
<td>Diverticulosis of large intestine without perforation or abscess with bleeding</td>
<td>ICD-10-CM</td>
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<td>K57.33</td>
<td>Diverticulitis of large intestine without perforation or abscess with bleeding</td>
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<td>Angiodysplasia of colon with hemorrhage</td>
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<td>K63.81</td>
<td>Dieulafoy lesion of intestine</td>
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<td>Hematemesis</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K92.1</td>
<td>Melena</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K92.2</td>
<td>Gastrointestinal hemorrhage, unspecified</td>
<td>ICD-10-CM</td>
</tr>
</tbody>
</table>

**ICD-10-CM (Forward-Backward Mapping)**

| K22.11 | Ulcer of esophagus with bleeding                      | ICD-10-CM          |
| K25.0  | Acute gastric ulcer with hemorrhage                   | ICD-10-CM          |
| K25.2  | Acute gastric ulcer with both hemorrhage and perforation | ICD-10-CM          |
| K25.4  | Chronic or unspecified gastric ulcer with hemorrhage  | ICD-10-CM          |
| K26.0  | Acute duodenal ulcer with hemorrhage                  | ICD-10-CM          |
| K26.2  | Acute duodenal ulcer with both hemorrhage and perforation | ICD-10-CM          |
| K26.4  | Chronic or unspecified duodenal ulcer with hemorrhage | ICD-10-CM          |
| K26.6  | Chronic or unspecified duodenal ulcer with both hemorrhage and perforation | ICD-10-CM          |
| K27.0  | Acute peptic ulcer, site unspecified, with hemorrhage | ICD-10-CM          |
| K27.2  | Acute peptic ulcer, site unspecified, with both hemorrhage and perforation | ICD-10-CM          |
| K27.4  | Chronic or unspecified peptic ulcer, site unspecified, with hemorrhage | ICD-10-CM          |
| K27.6  | Chronic or unspecified peptic ulcer, site unspecified, with both hemorrhage and perforation | ICD-10-CM          |
| K28.0  | Acute gastrojejunal ulcer with hemorrhage             | ICD-10-CM          |
| K28.2  | Acute gastrojejunal ulcer with both hemorrhage and perforation | ICD-10-CM          |
| K28.4  | Chronic or unspecified gastrojejunal ulcer with hemorrhage | ICD-10-CM          |
| K28.6  | Chronic or unspecified gastrojejunal ulcer with both hemorrhage and perforation | ICD-10-CM          |
| K29.01 | Acute gastritis with bleeding                         | ICD-10-CM          |
| K29.21 | Alcoholic gastritis with bleeding                     | ICD-10-CM          |
| K29.31 | Chronic superficial gastritis with bleeding           | ICD-10-CM          |
| K29.41 | Chronic atrophic gastritis with bleeding              | ICD-10-CM          |
| K29.51 | Unspecified chronic gastritis with bleeding           | ICD-10-CM          |
| K29.61 | Other gastritis with bleeding                         | ICD-10-CM          |
| K29.71 | Gastritis, unspecified, with bleeding                 | ICD-10-CM          |
| K29.81 | Duodenitis with bleeding                              | ICD-10-CM          |
| K29.91 | Gastroduodenitis, unspecified, with bleeding          | ICD-10-CM          |
| K31.811| Angiodysplasia of stomach and duodenum with bleeding  | ICD-10-CM          |
| K31.82 | Dieulafoy lesion (hemorrhagic) of stomach and duodenum | ICD-10-CM          |
| K55.21 | Angiodysplasia of colon with hemorrhage               | ICD-10-CM          |
| K56.60 | Unspecified intestinal obstruction                    | ICD-10-CM          |
| K57.01 | Diverticulitis of small intestine with perforation and abscess with bleeding | ICD-10-CM          |
| K57.11 | Diverticulosis of small intestine without perforation or abscess with bleeding | ICD-10-CM          |
| K57.13 | Diverticulitis of small intestine without perforation or abscess with bleeding | ICD-10-CM          |
| K57.21 | Diverticulitis of large intestine with perforation and abscess with bleeding | ICD-10-CM          |
| K57.31 | Diverticulosis of large intestine without perforation or abscess with bleeding | ICD-10-CM          |
Appendix B. List of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes Used to Define Gastrointestinal Bleeding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>K57.33</td>
<td>Diverticulitis of large intestine without perforation or abscess with bleeding</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K57.41</td>
<td>Diverticulitis of both small and large intestine with perforation and abscess with bleeding</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K57.51</td>
<td>Diverticulosis of both small and large intestine without perforation or abscess with bleeding</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K57.53</td>
<td>Diverticulitis of both small and large intestine without perforation or abscess with bleeding</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K57.81</td>
<td>Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K57.91</td>
<td>Diverticulosis of intestine, part unspecified, without perforation or abscess with bleeding</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K57.93</td>
<td>Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K63.81</td>
<td>Dieulafoy lesion of intestine</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K92.0</td>
<td>Hematemesis</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K92.1</td>
<td>Melena</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>K92.2</td>
<td>Gastrointestinal hemorrhage, unspecified</td>
<td>ICD-10-CM</td>
</tr>
</tbody>
</table>
Appendix C. Specifications for Parameters for this Request

Sentinel’s Cohort Identification and Descriptive Analysis (CIDA) module version 3.3.6 was used to compare the frequency of diagnoses for gastrointestinal bleeding using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

<table>
<thead>
<tr>
<th>Event</th>
<th>Incident with Respect To:</th>
<th>Washout (days)</th>
<th>Cohort Definition</th>
<th>Care Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal Bleeding</td>
<td>ICD-9-CM</td>
<td>ICD-9-CM</td>
<td>90</td>
<td>First valid event only</td>
</tr>
<tr>
<td>Gastrointestinal Bleeding</td>
<td>ICD-10-CM algorithm</td>
<td>90</td>
<td>First valid event only</td>
<td>IPP</td>
</tr>
<tr>
<td>Gastrointestinal Bleeding</td>
<td>ICD-10-CM Forward-Backward Mapping (FBM)</td>
<td>90</td>
<td>First valid event only</td>
<td>IPP</td>
</tr>
<tr>
<td>Gastrointestinal Bleeding</td>
<td>ICD-9-CM or ICD-10-CM algorithm</td>
<td>183</td>
<td>First valid event only</td>
<td>IPP</td>
</tr>
<tr>
<td>Gastrointestinal Bleeding</td>
<td>ICD-9-CM or ICD-10-CM FBM</td>
<td>183</td>
<td>First valid event only</td>
<td>IPP</td>
</tr>
<tr>
<td>Gastrointestinal Bleeding</td>
<td>ICD-9-CM or ICD-10-CM algorithm</td>
<td>183</td>
<td>First valid event only</td>
<td>IPP</td>
</tr>
<tr>
<td>Gastrointestinal Bleeding</td>
<td>ICD-9-CM or ICD-10-CM FBM</td>
<td>183</td>
<td>First valid event only</td>
<td>IPP</td>
</tr>
</tbody>
</table>

ICD-9-CM and ICD-10-CM are provided by Optum360. ICD-10-CM codes were mapped from ICD-9-CM codes using the Centers for Medicare and Medicaid Services General Equivalence Mappings.