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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

Date Run: October 25, 2017

Request Description: The purpose of this report was to compare the frequency of diagnoses for gastrointestinal hemorrhage 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 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 Modular Program Tool Used: Cohort Identification and Descriptive Analysis (CIDA) tool, version 5.0.5

Data Source: This request was run against data from 12 Data Partners contributing to the Sentinel Distributed Database (SDD). Data from October 1, 2010 to September 30, 2016 were included in this report. The report includes three separate time periods: 1) October 1, 2010 to September 30, 2016; 2) April 1, 2015 to September 30, 2015; and 3) April 1, 2016 to September 30, 2016. This request was distributed to Data Partners on October 25, 2017. See Appendix A for a list of dates of available data for each Data Partner.

Study Design: We examined the incidence and prevalence across the ICD-9-CM era (October 2010 - September 2015) and ICD-10-CM era (October 2015 - September 2016) in the United States. Incidence was additionally evaluated from April 2015 to September 2015 and April 2016 to September 2016. See Appendix B for specific codes used to define gastrointestinal hemorrhage in this request.

Cohort Eligibility Criteria: Members included in the cohort were required to be continuously enrolled in health plans with medical and drug coverage for at least six months (183 days) before their diagnosis date, during which gaps in coverage of up to 45 days were allowed. The following age groups were included in the cohort: 21-64, 65-74, 75-84, and 85-99 years.

Incident Cohorts: Members included in the incident cohorts were required to be continuously enrolled in health plans with medical and drug coverage for at least 183 days prior to gastrointestinal hemorrhage diagnosis, during which gaps in coverage of up to 45 days were allowed. Incident gastrointestinal hemorrhage was defined as no previous gastrointestinal hemorrhage diagnosis in the 183 days preceding the index date with respect to ICD-9-CM and ICD-10-CM codes.

Prevalent Cohorts: There was no enrollment time requirement for members in the prevalent cohorts. All qualifying diagnosis codes that occurred between October 1, 2010 and September 30, 2016 were included.

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.

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

¹Fung, K. W., et al. (2016). "Preparing for the ICD-10-CM Transition: Automated Methods for Translating ICD Codes in Clinical Phenotype Definitions." EGEMS (Wash DC) 4(1): 1211.

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**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 Hemorrhage 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 (April 1, 2015 - September 30, 2015 and April 1, 2016 - September 30, 2016)

	Members with Diagnosis	Eligible Members	Members with Diagnosis per 1,000 Eligible Members
Gastrointestinal Hemorrhage			
ICD-9-CM: April 1, 2015 - September 30, 2015	302,286	32,296,709	9.36
ICD-10-CM: April 1, 2016 - September 30, 2016	323,975	33,660,949	9.62

*Incidence defined by a 183 day washout

Figure 1. Incidence of Gastrointestinal Hemorrhage Diagnoses per 1,000 Eligible Members from October 2010 - September 2016 by Code Type, 183-Day Washout

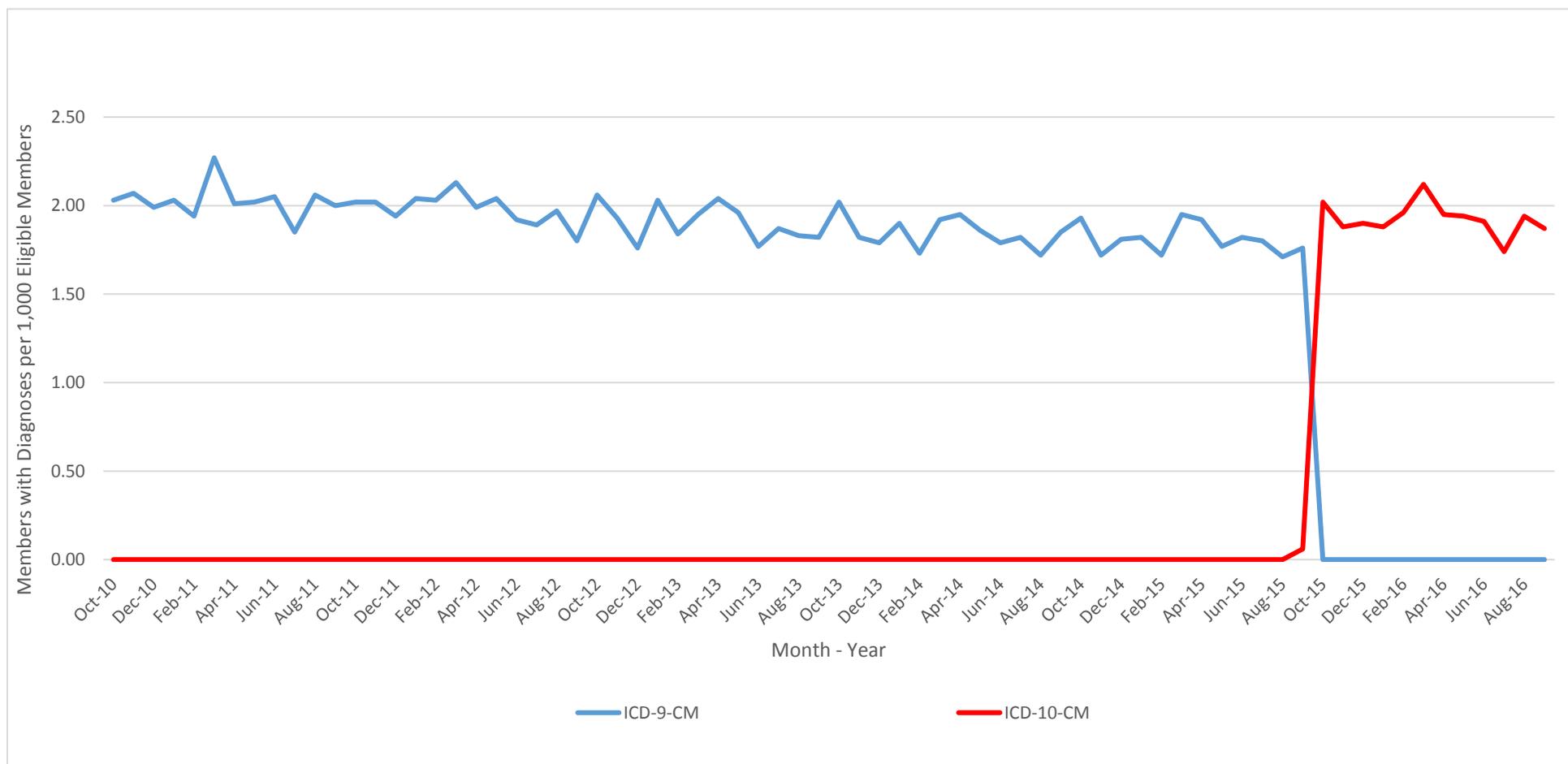
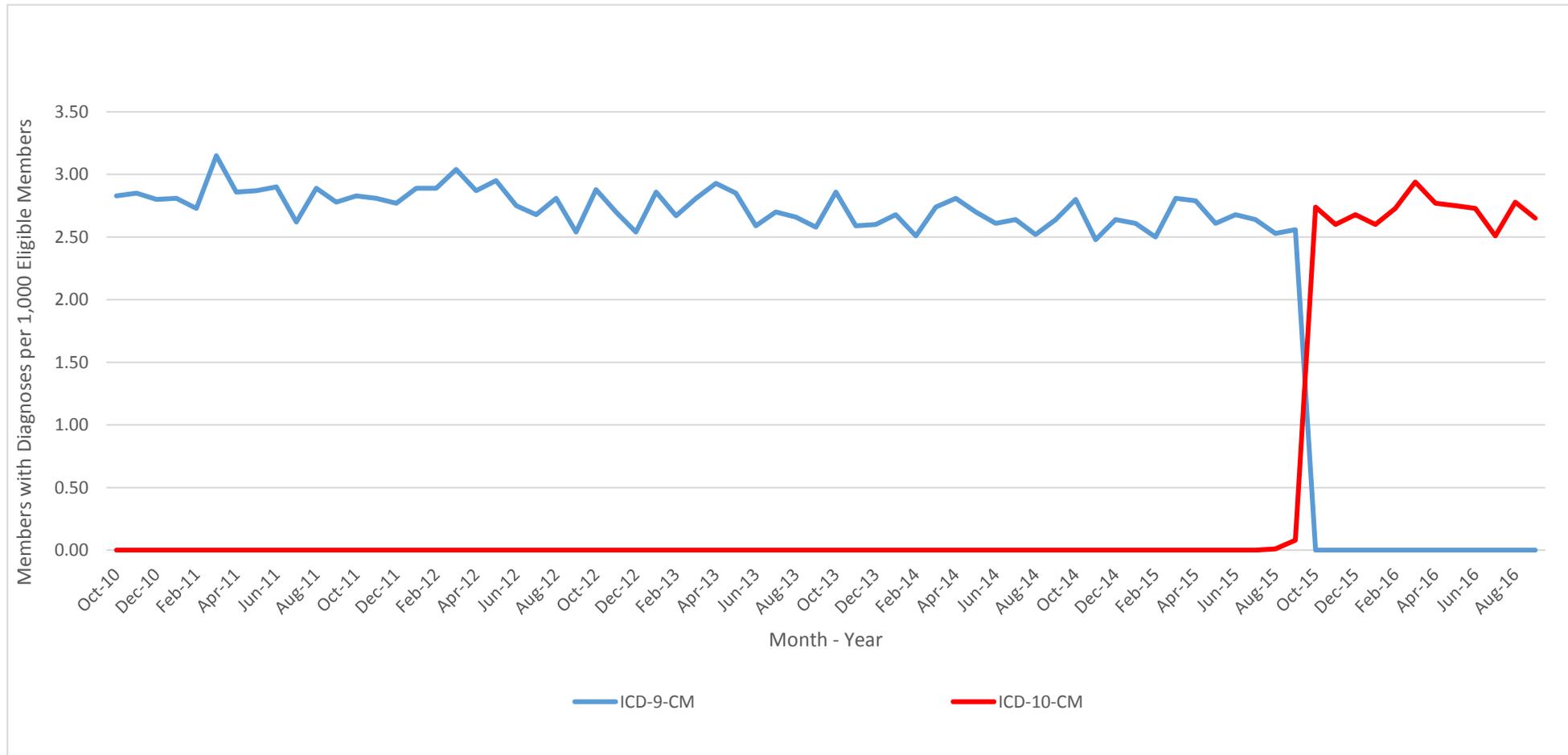


Figure 2. Prevalence of Gastrointestinal Hemorrhage Diagnoses per 1,000 Eligible Members from October 2010 - September 2016 by Code Type, 0-Day Washout



Appendix A. Dates of Available Data for Each Data Partner as of Request Distribution Date (October 25, 2017)

DP ID	Start Date¹	End Date¹
DP0001	10/1/2010	6/30/2016
DP0002	10/1/2010	6/30/2016
DP0003	10/1/2010	9/30/2016
DP0004	10/1/2010	9/30/2016
DP0005	10/1/2010	9/30/2016
DP0006	10/1/2010	9/30/2016
DP0007	10/1/2010	9/30/2016
DP0008	10/1/2010	9/30/2016
DP0009	10/1/2010	9/30/2016
DP0010	10/1/2010	9/30/2016
DP0011	10/1/2010	9/30/2016
DP0012	10/1/2010	9/30/2016

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

Appendix B. List of 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 Hemorrhage

Code	Description	Code Type
ICD-9-CM		
455.2	Internal hemorrhoids with other complication	ICD-9-CM
455.5	External hemorrhoids with other complication	ICD-9-CM
456.0	Esophageal varices with bleeding	ICD-9-CM
456.20	Esophageal varices with bleeding in diseases classified elsewhere	ICD-9-CM
530.7	Gastroesophageal laceration-hemorrhage syndrome	ICD-9-CM
530.82	Esophageal hemorrhage	ICD-9-CM
531.0	Acute gastric ulcer with hemorrhage	ICD-9-CM
531.00	Acute gastric ulcer with hemorrhage, without mention of obstruction	ICD-9-CM
531.01	Acute gastric ulcer with hemorrhage and obstruction	ICD-9-CM
531.1	Acute gastric ulcer with perforation	ICD-9-CM
531.10	Acute gastric ulcer with perforation, without mention of obstruction	ICD-9-CM
531.11	Acute gastric ulcer with perforation and obstruction	ICD-9-CM
531.2	Acute gastric ulcer with hemorrhage and perforation	ICD-9-CM
531.20	Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction	ICD-9-CM
531.21	Acute gastric ulcer with hemorrhage, perforation, and obstruction	ICD-9-CM
531.3	Acute gastric ulcer without mention of hemorrhage or perforation	ICD-9-CM
531.30	Acute gastric ulcer without mention of hemorrhage, perforation, or obstruction	ICD-9-CM
531.31	Acute gastric ulcer without mention of hemorrhage or perforation, with obstruction	ICD-9-CM
531.4	Chronic or unspecified gastric ulcer with hemorrhage	ICD-9-CM
531.40	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction	ICD-9-CM
531.41	Chronic or unspecified gastric ulcer with hemorrhage and obstruction	ICD-9-CM
531.5	Chronic or unspecified gastric ulcer with perforation	ICD-9-CM
531.50	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction	ICD-9-CM
531.51	Chronic or unspecified gastric ulcer with perforation and obstruction	ICD-9-CM
531.6	Chronic or unspecified gastric ulcer with hemorrhage and perforation	ICD-9-CM
531.60	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction	ICD-9-CM
531.61	Chronic or unspecified gastric ulcer with hemorrhage, perforation, and obstruction	ICD-9-CM
532.0	Acute duodenal ulcer with hemorrhage	ICD-9-CM
532.00	Acute duodenal ulcer with hemorrhage, without mention of obstruction	ICD-9-CM
532.01	Acute duodenal ulcer with hemorrhage and obstruction	ICD-9-CM
532.1	Acute duodenal ulcer with perforation	ICD-9-CM
532.10	Acute duodenal ulcer with perforation, without mention of obstruction	ICD-9-CM
532.11	Acute duodenal ulcer with perforation and obstruction	ICD-9-CM
532.2	Acute duodenal ulcer with hemorrhage and perforation	ICD-9-CM
532.20	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction	ICD-9-CM
532.21	Acute duodenal ulcer with hemorrhage, perforation, and obstruction	ICD-9-CM
532.3	Acute duodenal ulcer without mention of hemorrhage or perforation	ICD-9-CM
532.30	Acute duodenal ulcer without mention of hemorrhage, perforation, or obstruction	ICD-9-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 Hemorrhage

Code	Description	Code Type
532.31	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction	ICD-9-CM
532.4	Chronic or unspecified duodenal ulcer with hemorrhage	ICD-9-CM
532.40	Duodenal ulcer, chronic or unspecified, with hemorrhage, without mention of obstruction	ICD-9-CM
532.41	Chronic or unspecified duodenal ulcer with hemorrhage and obstruction	ICD-9-CM
532.5	Chronic or unspecified duodenal ulcer with perforation	ICD-9-CM
532.50	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction	ICD-9-CM
532.51	Chronic or unspecified duodenal ulcer with perforation and obstruction	ICD-9-CM
532.6	Chronic or unspecified duodenal ulcer with hemorrhage and perforation	ICD-9-CM
532.60	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction	ICD-9-CM
532.61	Chronic or unspecified duodenal ulcer with hemorrhage, perforation, and obstruction	ICD-9-CM
533.0	Acute peptic ulcer, unspecified site, with hemorrhage	ICD-9-CM
533.00	Acute peptic ulcer, unspecified site, with hemorrhage, without mention of obstruction	ICD-9-CM
533.01	Acute peptic ulcer, unspecified site, with hemorrhage and obstruction	ICD-9-CM
533.1	Acute peptic ulcer, unspecified site, with perforation	ICD-9-CM
533.10	Acute peptic ulcer, unspecified site, with perforation, without mention of obstruction	ICD-9-CM
533.11	Acute peptic ulcer, unspecified site, with perforation and obstruction	ICD-9-CM
533.2	Acute peptic ulcer, unspecified site, with hemorrhage and perforation	ICD-9-CM
533.20	Acute peptic ulcer, unspecified site, with hemorrhage and perforation, without mention of obstruction	ICD-9-CM
533.21	Acute peptic ulcer, unspecified site, with hemorrhage, perforation, and obstruction	ICD-9-CM
533.3	Acute peptic ulcer, unspecified site, without mention of hemorrhage and perforation	ICD-9-CM
533.30	Acute peptic ulcer, unspecified site, without mention of hemorrhage, perforation, or obstruction	ICD-9-CM
533.31	Acute peptic ulcer, unspecified site, without mention of hemorrhage and perforation, with obstruction	ICD-9-CM
533.4	Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage	ICD-9-CM
533.40	Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage, without mention of obstruction	ICD-9-CM
533.41	Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage and obstruction	ICD-9-CM
533.5	Chronic or unspecified peptic ulcer, unspecified site, with perforation	ICD-9-CM
533.50	Chronic or unspecified peptic ulcer, unspecified site, with perforation, without mention of obstruction	ICD-9-CM
533.51	Chronic or unspecified peptic ulcer, unspecified site, with perforation and obstruction	ICD-9-CM
533.6	Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage and perforation	ICD-9-CM
533.60	Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage and perforation, without mention of obstruction	ICD-9-CM
533.61	Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage, perforation, and obstruction	ICD-9-CM
534.0	Acute gastrojejunal ulcer with hemorrhage	ICD-9-CM
534.00	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction	ICD-9-CM
534.01	Acute gastrojejunal ulcer, with hemorrhage and obstruction	ICD-9-CM
534.1	Acute gastrojejunal ulcer with perforation	ICD-9-CM

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Code	Description	Code Type
534.10	Acute gastrojejunal ulcer with perforation, without mention of obstruction	ICD-9-CM
534.11	Acute gastrojejunal ulcer with perforation and obstruction	ICD-9-CM
534.2	Acute gastrojejunal ulcer with hemorrhage and perforation	ICD-9-CM
534.20	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction	ICD-9-CM
534.21	Acute gastrojejunal ulcer with hemorrhage, perforation, and obstruction	ICD-9-CM
534.3	Acute gastrojejunal ulcer without mention of hemorrhage or perforation	ICD-9-CM
534.30	Acute gastrojejunal ulcer without mention of hemorrhage, perforation, or obstruction	ICD-9-CM
534.31	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction	ICD-9-CM
534.4	Chronic or unspecified gastrojejunal ulcer with hemorrhage	ICD-9-CM
534.40	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction	ICD-9-CM
534.41	Chronic or unspecified gastrojejunal ulcer, with hemorrhage and obstruction	ICD-9-CM
534.5	Chronic or unspecified gastrojejunal ulcer with perforation	ICD-9-CM
534.50	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction	ICD-9-CM
534.51	Chronic or unspecified gastrojejunal ulcer with perforation and obstruction	ICD-9-CM
534.6	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation	ICD-9-CM
534.60	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction	ICD-9-CM
534.61	Chronic or unspecified gastrojejunal ulcer with hemorrhage, perforation, and obstruction	ICD-9-CM
535.01	Acute gastritis with hemorrhage	ICD-9-CM
535.11	Atrophic gastritis with hemorrhage	ICD-9-CM
535.21	Gastric mucosal hypertrophy with hemorrhage	ICD-9-CM
535.31	Alcoholic gastritis with hemorrhage	ICD-9-CM
535.41	Other specified gastritis with hemorrhage	ICD-9-CM
535.51	Unspecified gastritis and gastroduodenitis with hemorrhage	ICD-9-CM
535.61	Duodenitis with hemorrhage	ICD-9-CM
537.83	Angiodysplasia of stomach and duodenum with hemorrhage	ICD-9-CM
562.02	Diverticulosis of small intestine with hemorrhage	ICD-9-CM
562.03	Diverticulitis of small intestine with hemorrhage	ICD-9-CM
562.12	Diverticulosis of colon with hemorrhage	ICD-9-CM
562.13	Diverticulitis of colon with hemorrhage	ICD-9-CM
568.81	Hemoperitoneum (nontraumatic)	ICD-9-CM
569.3	Hemorrhage of rectum and anus	ICD-9-CM
569.85	Angiodysplasia of intestine with hemorrhage	ICD-9-CM
578.0	Hematemesis	ICD-9-CM
578.1	Blood in stool	ICD-9-CM
578.9	Hemorrhage of gastrointestinal tract, unspecified	ICD-9-CM
ICD-10-CM		
I85.01	Esophageal varices with bleeding	ICD-10-CM
I85.11	Secondary esophageal varices with bleeding	ICD-10-CM
K22.6	Gastro-esophageal laceration-hemorrhage syndrome	ICD-10-CM
K22.8	Other specified diseases of esophagus	ICD-10-CM
K25.0	Acute gastric ulcer with hemorrhage	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 Hemorrhage

Code	Description	Code Type
K25.1	Acute gastric ulcer with perforation	ICD-10-CM
K25.2	Acute gastric ulcer with both hemorrhage and perforation	ICD-10-CM
K25.3	Acute gastric ulcer without hemorrhage or perforation	ICD-10-CM
K25.4	Chronic or unspecified gastric ulcer with hemorrhage	ICD-10-CM
K25.5	Chronic or unspecified gastric ulcer with perforation	ICD-10-CM
K25.6	Chronic or unspecified gastric ulcer with both hemorrhage and perforation	ICD-10-CM
K26.0	Acute duodenal ulcer with hemorrhage	ICD-10-CM
K26.1	Acute duodenal ulcer with perforation	ICD-10-CM
K26.2	Acute duodenal ulcer with both hemorrhage and perforation	ICD-10-CM
K26.3	Acute duodenal ulcer without hemorrhage or perforation	ICD-10-CM
K26.4	Chronic or unspecified duodenal ulcer with hemorrhage	ICD-10-CM
K26.5	Chronic or unspecified duodenal ulcer with perforation	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
K27.1	Acute peptic ulcer, site unspecified, with perforation	ICD-10-CM
K27.2	Acute peptic ulcer, site unspecified, with both hemorrhage and perforation	ICD-10-CM
K27.3	Acute peptic ulcer, site unspecified, without hemorrhage or perforation	ICD-10-CM
K27.4	Chronic or unspecified peptic ulcer, site unspecified, with hemorrhage	ICD-10-CM
K27.5	Chronic or unspecified peptic ulcer, site unspecified, with perforation	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
K28.1	Acute gastrojejunal ulcer with perforation	ICD-10-CM
K28.2	Acute gastrojejunal ulcer with both hemorrhage and perforation	ICD-10-CM
K28.3	Acute gastrojejunal ulcer without hemorrhage or perforation	ICD-10-CM
K28.4	Chronic or unspecified gastrojejunal ulcer with hemorrhage	ICD-10-CM
K28.5	Chronic or unspecified gastrojejunal ulcer with perforation	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
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
K57.33	Diverticulitis 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 Hemorrhage

Code	Description	Code Type
K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding	ICD-10-CM
K57.51	Diverticulosis of both small and large intestine without perforation or abscess with bleeding	ICD-10-CM
K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding	ICD-10-CM
K57.81	Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding	ICD-10-CM
K57.91	Diverticulosis of intestine, part unspecified, without perforation or abscess with bleeding	ICD-10-CM
K57.93	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding	ICD-10-CM
K62.5	Hemorrhage of anus and rectum	ICD-10-CM
K66.1	Hemoperitoneum	ICD-10-CM
K92.0	Hematemesis	ICD-10-CM
K92.1	Melena	ICD-10-CM
K92.2	Gastrointestinal hemorrhage, unspecified	ICD-10-CM

Appendix C. Specifications for Parameters for this Request

Sentinel's Cohort Identification and Descriptive Analysis (CIDA) tool version 5.0.5 was used to compare the frequency of diagnoses for gastrointestinal hemorrhage 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.

Enrollment Gap: 45 days
Age Groups: 21-64, 65-74, 75-84, 85-99 years
Enrollment Requirement: 183 days for incidence scenarios; 0 days for prevalence scenarios
Coverage Requirement: Medical and drug coverage

Scenario	Query Start Date	Query End Date	Event					Cohort Definition	Care Setting
			Event	Event Code Type	Incident with Respect To:	Washout (days)			
1	4/1/2015	9/30/2015	Gastrointestinal Hemorrhage	ICD-9-CM	ICD-9-CM	183	First valid event only	Any	
2	4/1/2016	9/30/2016	Gastrointestinal Hemorrhage	ICD-10-CM	ICD-10-CM	183	First valid event only	Any	
3	10/1/2010	9/30/2016	Gastrointestinal Hemorrhage	ICD-9-CM	ICD-9-CM or ICD-10-CM	183	Any valid events	Any	
4	10/1/2010	9/30/2016	Gastrointestinal Hemorrhage	ICD-10-CM	ICD-9-CM or ICD-10-CM	183	Any valid events	Any	
5	10/1/2010	9/30/2016	Gastrointestinal Hemorrhage	ICD-9-CM	N/A	0	Any valid events	Any	
6	10/1/2010	9/30/2016	Gastrointestinal Hemorrhage	ICD-10-CM	N/A	0	Any valid events	Any	

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.