Supplementary Table 1. Diagnosis and procedural codes used to define the inclusion and exclusion criteria for the study.

Criterion	Code / Definition
Inclusion Criteria	
Type 2 diabetes mellitus	ICD-10: E11.xx
Diabetic retinopathy (≥2 ICD-coded DR encounters)	ICD-10: E10.30-E10.39, E11.30-E11.39, E13.30-E13.39
Exclusion Criteria	
Panretinal photocoagulation (PRP) before index date	CPT: 67228
Pars plana vitrectomy (PPV) before index date	CPT: 67036, 67039–67043, 67108, 67113
Mild or moderate NPDR with concurrent vitreous haemorrhage at baseline (misclassification risk)	ICD-10: H43.1xx
Baseline PDR (excluded from PDR progression risk set)	ICD-10: E10.35x, E11.35x, E13.35x
Baseline severe NPDR or PDR (excluded from severe NPDR progression risk set)	ICD-10: E10.34x, E11.34x, E13.34x; E10.35x, E11.35x, E13.35x

DR = diabetic retinopathy; ICD-10 = International Classification of Diseases, Tenth Revision; CPT = Current Procedural Terminology; NPDR = non-proliferative diabetic retinopathy; PDR = proliferative diabetic retinopathy; PRP = panretinal photocoagulation; PPV = pars plana vitrectomy.