AAVBC

American Academy
of Value Based Care

Substance Use Disorder

Quick Reference Guide

2025

AAVBC Substance Use Disorder Quick Reference Guide

1. CLINICAL SNAPSHOT

Definition: Substance Use Disorder (SUD) is a complex, chronic relapsing brain condition marked by compulsive use despite harm, associated with neurobiologic changes in reward, stress, and self-control circuits; severity is based on DSM-5 criteria (2–3 = mild, 4–5 = moderate, ≥6 = severe)[1,2]**ICD-10 Codes:** F10.x (alcohol), F11.x (opioids), F12.x (cannabis), F14.x (cocaine), F15.x (stimulants), F16.x (hallucinogens), F17.x (tobacco/nicotine), F18.x (inhalants/volatile solvents), F19.x (polysubstance)[3]

HCC V28 Mapping: HCC 135 (Drug Use with Psychotic Complications) F11.x, F14.x - F19.x with RAF (0.424), **HCC 136** (AUD with Psychotic Complications) F10.x with RAF (0.424), **HCC 137** (Drug Use Disorder, Moderate/Severe or With Specified Non-Psychotic Complications) F10.x- F12.x,F14.x - F19.x with RAF (0.424) **HCC 138** (Drug Use Disorder Mild, uncomplicated) F11.x, F14.x-F19.x with RAF (0.423) **HCC 139** (AUD, Moderate/Severe or With Specified Non-Psychotic Complications) F10.x with RAF (0.242); Opioid use disorder and co-occurring disorders used to add interaction factors; no longer do in V28[4,5]

Prevalence (U.S.): ≈48.7M individuals ≥12 w/ past-year SUD, 17.4% of adults (2022). , costs $15,640 (mean) PMPY. Annual cost per OUD case (excluding patient burden) ≈US $163,000, across all stakeholders, not just medical care. In 2024, among those classified as needing SUD treatment, 19.3% received care (80.7% untreated), 107,543 overdose deaths (2023), relapse rate 40-60% within 6 months[6-9]

2. RECOGNITION & DIAGNOSIS

Medicare Screenings

Test	Coverage	Frequency	CPT/HCPCS Code	Notes
SBIRT screening	Universal	Annual	G0442(screen)	15 min brief intervention
Alcohol screening	Covered	Annual	G0443	if positive, up to 4 brief face-to-face counseling sessions in 12 mo
Depression screen	Covered	Annual	G0444	Co-occurring common
Hepatitis C	Covered for high risk	Once lifetime, periodically for risk	G0472 G0567	CMS now also allows G0567 NAAT screening (effective 6/27/2024)
HIV screening	Covered	Annual if risk	G0475	High-risk populations

Subtle Early Signs in Adults >65 yrs[10-12]

- **Frequent falls or gait instability** → Alcohol and benzodiazepines increase fall/fracture risk in older adults; ask specifically about "nightcap," OTC sleep aids, and PRN benzos.check BAL even if "denies drinking"
- **New-onset anxiety/insomnia** → Chronic benzodiazepine use (incl. "as needed") is potentially inappropriate in older adults (Beers Criteria); screen for physiologic dependence and discuss taper/alternatives
- **Cognitive changes** → Consider alcohol-related cognitive impairment and thiamine deficiency
- **Social isolation** → Late-life initiation or escalation of alcohol/misuse can follow loss, loneliness, or role change
- **Multiple pharmacy use** → Doctor shopping;heightened risk for unsafe combinations (e.g., opioids + benzos, Z-drugs); check PDMP before initiating/continuing controlled substances and at least every 3 months if prescribing

Geriatric Risk Factors

Factor	Risk Signal	Evidence Summary	Clinical Implication
Chronic pain[13,14]	30–40 % long term users meet criteria for misuse	Persistent pain and musculoskeletal disorders are major drivers of **opioid prescribing**	Use lowest effective dose and shortest duration; prefer multimodal non-opioid therapies
Sleep disorders/anxiety[11]	risk of physiologic dependence ≈ 15–30% after months of daily use.	Chronic **benzodiazepine** or **Z-drug** use in older adults increases fall, delirium, and cognitive-impairment risk	Re-evaluate need at every visit; taper when feasible; favor CBT-I or SSRI/buspirone
Recent loss/grief or social isolation[4]	Relative Risk 2.0-3.0	Late-life alcohol use commonly follows bereavement, loneliness, or role change	Screen for alcohol misuse
Prior SUD history[9]	Odds Ratio 2.0 - 6.0	Relapse risk increases with social isolation and chronic pain	Maintain ongoing follow-up even in sustained remission; address triggers
Polypharmacy (>5 meds)[11]	Odds Ratio 1.25, increased risk if early onset	**Each** CNS-active drugs **amplify** sedation, confusion, and fall risk; alcohol and benzodiazepines potentiate adverse events	Review medication list and PDMP quarterly; deprescribe when possible

RED FLAGS - URGENT ACTION[15,16]

- **Alcohol withdrawal / risk of delirium tremens (DTs):** Disorientation, autonomic instability, seizures, or CIWA-Ar rising within 48–96 h after last drink → Escalate level of care. Use symptom-triggered benzodiazepines guided by CIWA-Ar; admit if history of severe withdrawal, seizures, or significant comorbidity

- **Suspected Opioid overdose:** Pinpoint pupils, respiratory rate <12, unresponsive → Naloxone **immediately** and activate EMS; provide rescue breathing and monitor for re-sedation after reversal
- **Serotonin syndrome:** Hyperthermia, clonus, altered mental status with SSRI + tramadol
- **Benzodiazepine withdrawal:** Tremor, agitation, insomnia, perceptual disturbance, seizures (esp. with abrupt cessation of high-dose or short-acting agents) → Avoid abrupt discontinuation; gradual taper with longer-acting agent and supportive care; consider higher level of care if complicated
- **Possible Wernicke encephalopathy:** (chronic alcohol use or malnutrition) Confusion, ataxia, ophthalmoplegia → **Give parenteral thiamine promptly** (before glucose when feasible) and continue for several days; do not delay treatment while awaiting imaging

Diagnostic Thresholds

Tool	Positive Screen	Action
AUDIT-C[17] (alcohol abuse)	≥4 men; ≥3 women	Proceed to full AUDIT and DSM-5-TR assessment; brief intervention if hazardous use
CAGE[17] (alcohol abuse)	≥2 positive	Further assessment for AUD; not a severity tool
DAST-10[18] (drug abuse)	**≥3** = positive screen (moderate risk); 6–8 substantial; 9–10 severe	Substance-specific assessment; consider UDT and referral as indicated
COWS (opioid withdrawal)[17]	13–24 = moderate, 25–36 = moderately severe, >36 = severe	Use to guide buprenorphine induction and titration; avoid precipitated withdrawal
CIWA-Ar (alcohol withdrawal)[15]	≥8: consider medication; >15 = severe	Symptom-triggered benzodiazepines; escalate level of care for severe/complicated cases

Clues to Dig Deeper

- **Macrocytosis (elevated MCV) ± normal/mildly abnormal GGT** → consider chronic alcohol use; biomarkers like PEth/CDT aid confirmation when history is uncertain (GGT/MCV are nonspecific)
- **Recurrent or chronic pancreatitis** → alcohol is a major cause; ask explicitly about intake and timing of last drink
- **Apparent "resistant" hypertension or labile BP** → alcohol can raise BP; assess intake and advise reduction/abstinence[15]
- **Peripheral neuropathy or malnutrition** → consider alcohol-related thiamine deficiency; give thiamine when concern is high[15]

Common Oversights

- **"Just 1–2 drinks/day is fine"** → Older adults are more alcohol-sensitive (↓ total body water, ↓ hepatic clearance, ↑ brain sensitivity); recommend ≤1 st drink/day or ≤7/week, screen even moderate drinkers[9, 10]

- **Missing prescriptions/misuse** → Late-life SUDs often involve "as prescribed" benzodiazepines, opioids, or sedative-hypnotics. Verify with PDMP, med reconciliation, and collateral history[10]
- **Assuming "too old to have addiction"** → Fastest growing SUD demographic is >65[9]
- **Not screening for tobacco/nicotine** → Co-use is common; nicotine treatment improves overall SUD outcomes; Offer cessation along with SUD care[10]

Key Differentials in Elderly

Presentation	Differential	Key Tests
Confusion + falls[11]	Alcohol effects vs dementia vs polypharmacy	Serum ethanol if any suspicion; CMP, B12, medication review; consider withdrawal risk (CIWA)
Tremor[15]	Alcohol/sedative withdrawal vs essential vs Parkinson's	Timeline (last drink/benzo), CIWA-Ar, tox screen; if unclear, neuro exam ± DaT scan per neurology
Depression[1]	Primary mood disorder vs substance-induced depression	PHQ-9; TSH; targeted tox screen; re-assess after early abstinence
Chronic pain[14]	Physiologic dependence vs OUD; pseudoaddiction vs undertreated pain	PDMP; pain/function diary; consider opioid risk tool; urine drug testing when clinically indicated

Comorbidity Screening[9,20]

Condition	Why	Screening
Depression	1 in 4 (22 %) adults w/ SUD experienced a MDE, and almost half (47 %) of adults w/ depression had a co-occurring SUD	**PHQ-9** at intake and periodically during treatment (e.g., every 3 months or w/ clinical change)
Anxiety disorders	About 1 in 4 (24 %) adults with SUD met criteria for an anxiety disorder.	**GAD-7** at intake; repeat to track symptoms
PTSD	1 in 10 (10 %) adults with SUD had PTSD; 30 % of adults with PTSD met SUD criteria	**PC-PTSD-5** at intake if trauma exposure or symptoms are present
Hepatitis C	Injection and other exposures elevate risk; treatable if found	**Anti-HCV antibody** once for all adults 18–79 and periodically for ongoing risk (e.g., people who inject drugs)
HIV	Elevated risk with injection or high-risk sexual behaviors	**HIV Ag/Ab** testing at least annually for patients with ongoing risk (e.g., injection drug use, new partners)

Staging/Severity[1,21]

Stage	DSM-5-TR Diagnostic Criteria	Management
Mild	Meets 2-3 criteria	Brief intervention - primary care or telehealth; SBIRT model effective for alcohol/cannabis
Moderate	Meets 4-5 criteria	Structured outpatient or intensive outpatient (IOP); weekly therapy and MAT if indicated; monitor withdrawal risk

Severe	Meets ≥6 criteria	Residential or inpatient treatment w/ medical and psychosocial stabilization; initiate/continue MAT; coordinate transition to outpatient
Remission	<2 criteria x12mo	Continue monitoring and relapse-prevention (counseling, peer recovery, periodic drug screens)

3. MEAT DOCUMENTATION ESSENTIALS[3-5,14,15]

MONITOR: "AUDIT-C score 8 [date], increased from 5 six months ago. Daily alcohol intake 6-8 drinks (patient reports 'few beers'), up from 3-4. CIWA-Ar score 12 indicating moderate withdrawal. LFTs: AST 92, ALT 48, GGT 180 (2x normal), MCV 102. Weight loss 15 lbs over 3 months. Hand tremor noted, worse in morning"

EVALUATE: "Comprehensive SUD assessment [date]: Meets 7/11 DSM-5 criteria for severe alcohol use disorder - tolerance (needs 8 drinks for effect), withdrawal (morning shakes), larger amounts than intended, unsuccessful quit attempts x3, time spent obtaining/recovering, missed family events, continued use despite cirrhosis diagnosis. PDMP check shows 3 prescribers for benzodiazepines. PHQ-9 score 18 (moderate-severe depression). Social history: widowed 8 months ago, drinks alone daily"

ASSESS: "Severe alcohol use disorder (F10.20) with physiological dependence, complicated by alcohol withdrawal syndrome (F10.239) with CIWA 12, major depression (F33.1) likely substance-induced vs independent, mild hepatic steatosis (K70.0), and high-risk prescription pattern with concurrent benzodiazepine use from multiple providers increasing overdose risk 10-fold"

TREAT: "Admitted for medical detox: Chlordiazepoxide 50mg q6h day 1, taper over 5 days per CIWA protocol. Started naltrexone 50mg daily after LFTs stable (AST<2x normal). Initiated gabapentin 300mg TID for protracted withdrawal/anxiety. Referred to intensive outpatient program (IOP) 3x/week. Enrolled in SMART Recovery. Psychiatry consulted for depression management - started sertraline 50mg daily. Vitamin supplementation: thiamine 100mg, folate 1mg, MVI daily"

Critical RADV Elements

- **Specify substance class:** Use the exact ICD-10-CM code "Opioid dependence" (F11.20) NOT "drug dependence" (F19.20)
- **Include complications:** " dependence with intoxication delirium" (F10.121) or “Opioid dependence with withdrawal” *(F11.23)* to capture acuity and risk
- **Document remission precisely**: Use “in early remission” (F10.21) or “in sustained remission” (F10.21 + duration ≥ 12 mo); never “history of.”
- **Link comorbid conditions:** State casual link "Alcoholic cirrhosis" (K70.30) NOT separate “ alcohol use + cirrhosis”
- **Confirm MEAT presence**: Every diagnosis must show Monitoring, Evaluation, Assessment, Treatment in the same calendar year for CMS capture

Audit-Proof Tips

Instead of...	Document...
"History of alcoholism"	"Severe alcohol use disorder (F10.20), currently active, drinking 750mL vodka daily"
"Drug abuse"	"Moderate opioid use disorder (F11.20), on MAT with buprenorphine 16mg daily"
"Doing well"	"In early remission x3 months, attending AA 3x/week, sponsor contact confirmed"
"Polysubstance abuse"	"Severe cocaine use disorder (F14.20) with mild cannabis use disorder (F12.10)"

4. TREATMENT & REFERRAL QUICK GUIDE

Therapy Escalation Criteria[15, 21, 22]

Trigger	Action	Expected Outcome
Failed brief intervention	IOP referral or or ASAM Level 2.1	Structured therapy improves remission likelihood by ~40%
Multiple relapses	Step-up to Residential Treatment (ASAM Level 3.5)	~60% higher abstinence and retention vs. standard outpatient
Severe or complicated withdrawal	Inpatient Detox (ASAM Level 4)	Prevent DTs/seizures and mortality; start pharmacotherapy early
Co-occurring psychiatric disorder	Integrated dual-diagnosis care	Combined SUD + mental health treatment yields 2× better remission and lower relapse

Evidence-Based Treatment Protocols[14-16, 21]

Substance / Disorder	First-Line	Dose/Duration	Monitoring
Alcohol (AUD)	Naltrexone (oral or XR-IM)	50mg PO daily or 380mg IM monthly	LFTs baseline → monthly ×3; avoid if acute hepatitis or LFT > 3× ULN
Alcohol (AUD)	Acamprosate	666mg PO TID	Check renal function
Opioid	Buprenorphine / naloxone	8–24 mg/day sublingual	PDMP check monthly; counsel on precipitated withdrawal
Opioid	Methadone	80-120mg/day titrated	ECG baseline/annual; monitor for QTc > 500 ms
Tobacco / Nicotine	Varenicline	0.5 mg daily ×3 days → 0.5 mg BID ×4 days → 1 mg BID ×12 wk	Screen for mood change; repeat course if relapse
Stimulant use disorder	Psychosocial intervention / Contingency Management	Monitor for response min 3 weeks. Continuing care is encouraged for up to **one year** for responders	Intensity adjusted based on severity and prior response. Monitor response with urine screens

Non-Rx Treatment Documentation

"Referred to Medicare-covered addiction counseling (individual CPT 90832-90837; group CPT 90853). Enrolled in an intensive outpatient program 9 hours/week. Peer recovery coach assigned through state program. Family therapy session scheduled (CPT 90847 covered when clinically indicated). Nutrition counseling for recovery (3 hours year 1 covered for malnutrition). Home breathalyzer provided for accountability"

When to Refer[4, 14, 21, 22]

Specialty	URGENT (<72 hours)	ROUTINE (1-2 weeks)
Addiction Medicine	Complicated withdrawal, pregnant + SUD	Failed outpatient x2
Psychiatry	Suicidal ideation, psychosis	Dual diagnosis (MDD, GAD, PTSD + SUD)
Hepatology	Variceal bleed, encephalopathy	Cirrhosis + ongoing alcohol use
Pain Management	Aberrant behavior on opioids	Chronic pain + SUD

Follow-up Timing[22]

- **Acute withdrawal:** Daily x3-5 days
- **Early recovery:** Weekly x4 weeks→ biweekly next 4 reinforce MAT adherence & relapse prevention
- **Maintenance MAT:** Monthly with PDMP review + urine drug screen
- **Stable remission:** Quarterly with annual assessment (labs, psychosocial stability)

Patient Education & Adherence

"Educated on naltrexone blocking opioid effects (carry wallet card for emergencies). Warned about reduced tolerance after abstinence - overdose risk if relapse. Taught HALT triggers (Hungry, Angry, Lonely, Tired). Provided SAMHSA helpline 1-800-662-4357. Narcan training for family with prescription provided. Created relapse prevention plan with specific triggers and coping strategies - document all education"

Comorbidity Management[11, 14, 22, 23]

Condition	Consideration	Management
Chronic pain	Avoid routine opioids; if used, close monitoring and PDMP or urine drug screens. Prefer multimodal non-opioid therapy	Acetaminophen, topical NSAIDs, duloxetine (neuropathic/MSK), gabapentin/pregabalin (neuropathic; monitor misuse), PT/exercise; behavioral pain programs
Anxiety	Avoid benzodiazepines in older adults/SUD	SSRI/SNRI, buspirone, psychotherapy (CBT). If on MAT, coordinate dosing/side-effects.
Insomnia	Avoid sedative-hypnotics and Z-drugs in older adults/SUD	CBT-I first line; consider ramelteon or low-dose doxepin; trazodone only if comorbid depression and after CBT-I trial
Depression	AUD/OUD tx can initially unmask/worsen mood; treat both conditions	Continue/adjust SSRI/SNRI; safety plan; psychotherapy. Avoid bupropion during heavy alcohol withdrawal/seizure risk.

Cost-Smart Options[24]

Brand	Generic/Alternative	Estimated Monthly Savings
Vivitrol	Oral naltrexone	$1,100
Suboxone film	Buprenorphine/naloxone tablets	$300
Chantix	Varenicline (generic) or combination NRT	$250
Brand naloxone	Generic naloxone (IN/IM)	$100

Quality Metrics Tie-In[4,25]

Measure	Definition	Impact
IET—Initiation and Engagement of Substance Use Disorder Treatment	Initiation: an SUD visit within 14 days of index diagnosis. Engagement: 2+ additional SUD services within 34 days after initiation.	Used by plans/Medicaid; improves retention and outcomes.
FUA—Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	7-day and 30-day timely follow-up after ED visit for AOD.	Impacts plan performance/Stars; reduces readmissions
POD—Pharmacotherapy for Opioid Use Disorder	% of members with new OUD episode who receive ≥180 days of MOUD (buprenorphine, methadone, or XR-naltrexone).	Quality and safety signal; associated with ↓ mortality
Annual screen (e.g., PHQ-9) with documented follow-up for positives.	Annual screen (e.g., PHQ-9) with documented follow-up for positive	Supports co-occurring care; audit-friendly

5. CODING REMINDERS & CASE EXAMPLES BOX[1, 3-5]

Specificity Requirements

- **Specify all four dimensions** → *substance type + severity + complication + remission status; "Alcohol use disorder, severe (F10.20), in early remission × 6 mo*
- **Use link/combination codes** → F10.231 (alcohol dependence with withdrawal delirium) NOT separate codes "Alcoholic cirrhosis (K70.30)" rather than separate alcohol + cirrhosis entries
- **Document timeline** → "Active use," "Early remission (1–12 mo)," "Sustained remission (> 12 mo)"
- **Avoid obsolete terms** → "abuse," "dependence NOS," "history of addiction." Use "use disorder" language.

Annual Capture

✓ **YES** - All SUD codes require annual face-to-face with MEAT by 12/31; video telehealth counts

✓ **V28 RAF:** Psychosis/dependence = 0.484, uncomplicated = 0

Common Denials & Fixes

Denial	Fix
"History of substance abuse"	→ "Alcohol use disorder, severe (F10.20), in sustained remission x2 years, attending AA weekly"
"Drug dependence"	→ "Opioid use disorder, moderate (F11.20), on buprenorphine 16mg daily, stable x6mo"
"Positive tox screen"	→ "Cocaine use disorder (F14.10), mild, last use 3/15/24 per UDS, enrolled IOP"
"Recovering alcoholic"	→ "Alcohol use disorder, severe, in early remission (F10.21), 4 months sober"

EHR Tips

- **.SUDSCREEN** template calculates AUDIT-C automatically
- **PDMP integration:** Auto-checks with each opioid/benzo prescription
- **Best practice alert:** Fires when prescribing opioids + benzos
- **Registry tracking:** Monthly reports for MAT compliance

Brief Case Examples

SUCCESS: "68yo with severe opioid use disorder (F11.20) following hip replacement 2018, currently on buprenorphine/naloxone 16/4mg daily with confirmed adherence via PDMP, attending IOP 3x/week, PHQ-9 improved from 18 to 8, in early remission x4 months"
→ Captures HCC 136 (0.424 RAF) = $4,411/year

PITFALL: "History of drug abuse" without specificity
→ Audit fail, loses RAF value

FIX: "Moderate stimulant use disorder (F15.20), methamphetamine type, last use 6/1/24 per UDS, enrolled in contingency management program with 8 consecutive negative screens"

QUICK REFERENCE TABLES

Withdrawal Timelines & Management

Substance	Onset	Peak	Duration	First-Line Treatment
Alcohol	6-24hr	24-72hr	5-7 days	Benzodiazepines
Opioids (short)	6-12hr	24-48hr	5-7 days	Buprenorphine
Opioids (long)	30hr	72-96hr	14 days	Clonidine + comfort
Benzos	1-4 days	2 weeks	2-8 weeks	Long-acting benzo taper
Stimulants	24hr	2-3 days	7-10 days	Supportive care

CIWA-Ar Scoring Guide

Score	Severity	Treatment
<8	Mild	Supportive care
8-15	Moderate	Medication PRN
>15	Severe	Standing medication + ICU consider

Medication-Assisted Treatment Options

Medication	Indication	Contraindications	Monitoring
Naltrexone	Alcohol, opioid	Active opioid use, hepatitis	LFTs monthly
Acamprosate	Alcohol	CrCl <30	Renal function
Disulfiram	Alcohol	Cardiac disease, psychosis	LFTs, supervision
Buprenorphine	Opioid	Respiratory depression	PDMP, UDS
Methadone	Opioid	QTc >500	ECG yearly

HCC Impact by Diagnosis

Diagnosis	ICD-10	HCC	RAF Score	Annual Value*
Drug use with psychosis	F10.5x, F11.5x	135	0.424	$4,411
Alcohol use with psychosis	F10.2x, F11.2x	136	0.424	$4,411

Diagnosis	ICD-10	HCC	RAF Score	Annual Value*
Drug use with psychosis	F10.5x, F11.5x	135	0.424	$4,411
SUD with complications	F10.1x, F11.1x	54	0	$0

*Based on $10,402.34 annual MA rate

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