



American Academy
of Value Based Care

Substance Use Disorder

Quick Reference Guide

2025

AAVBC Substance Use Disorder Quick Reference Guide

Table of Contents

1. CLINICAL SNAPSHOT.....	3
2. RECOGNITION & DIAGNOSIS.....	3
Medicare Screenings.....	3
Subtle Early Signs in Adults >65 yrs.....	3
Geriatric Risk Factors.....	4
RED FLAGS - URGENT ACTION.....	4
Diagnostic Thresholds.....	5
Clues to Dig Deeper.....	5
Common Oversights.....	5
Key Differentials in Elderly.....	6
Comorbidity Screening.....	6
Staging/Severity.....	6
3. MEAT DOCUMENTATION ESSENTIALS.....	7
Clinical Documentation Elements.....	7
Reframing Common Documentation Shortcuts.....	7
4. TREATMENT & REFERRAL QUICK GUIDE.....	8
Therapy Escalation Criteria.....	8
Evidence-Based Treatment Protocols.....	8
Non-Rx Treatment Documentation.....	9
When to Refer.....	9
Follow-up Timing.....	9
Patient Education & Adherence.....	9
Comorbidity Management.....	9
Cost-Smart Options.....	10
Quality Metrics Tie-In.....	10
5. CODING REMINDERS & CASE EXAMPLES BOX.....	11
Specificity Requirements.....	11
Annual Clinical Review and Confirmation.....	11
Good Documentation is Comprehensive Coding.....	11
EHR Tips.....	11
Brief Case Examples.....	12
6. QUICK REFERENCE TABLES.....	12
Withdrawal Timelines & Management.....	12
CIWA-Ar Scoring Guide.....	12
Medication-Assisted Treatment Options.....	12
HCC Impact by Diagnosis.....	13
REFERENCES.....	13

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), and a relapse rate of 40-60% within 6 months⁶⁻⁹

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 a 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 yrs¹⁰⁻¹²

- **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 the 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 drug amplifies 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-C¹⁷ (alcohol abuse)	≥4 men; ≥3 women	Proceed to full AUDIT and DSM-5-TR assessment; brief intervention if hazardous use
CAGE¹⁷ (alcohol abuse)	≥2 positive	Further assessment for AUD; not a severity tool
DAST-10¹⁸ (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 significant 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/abstinence¹⁵
- **Peripheral neuropathy or malnutrition** → consider alcohol-related thiamine deficiency; give thiamine when concern is high¹⁵

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 history¹⁰
- **Assuming “too old to have addiction”** → Fastest growing SUD demographic is >65⁹
- **Not screening for tobacco/nicotine** → Co-use is common; nicotine treatment improves overall SUD outcomes; Offer cessation along with SUD care¹⁰

Key Differentials in Elderly

Presentation	Differential	Key Tests
Confusion + falls¹¹	Alcohol effects vs dementia vs polypharmacy	Serum ethanol if any suspicion; CMP, B12, medication review; consider withdrawal risk (CIWA)
Tremor¹⁵	Alcohol/sedative withdrawal vs essential vs Parkinson's	Timeline (last drink/benzo), CIWA-Ar, tox screen; If unclear, neuro exam ± DaT scan per neurology
Depression¹	Primary mood disorder vs substance-induced depression	PHQ-9; TSH; targeted tox screen; re-assess after early abstinence
Chronic pain¹⁴	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 is 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 of 15 lbs over 3 months. Hand tremor noted, worse in the 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"

Clinical Documentation Elements

- **Specify substance class:** Use the exact ICD-10-CM code "Opioid dependence" (F11.20) NOT "drug dependence" (F19.20)
- **Clinical acuity and complications:** When intoxication, withdrawal, or delirium is present, specify the complication to reflect current risk and care needs: "dependence with intoxication delirium" (F10.121) or "Opioid dependence with withdrawal" (F11.23) to capture acuity and risk
- **Document remission status precisely:** Use "in early remission" (F10.21) or "in sustained remission" (F10.21 + duration ≥ 12 mo); never "history of."
- **Causal links to comorbid conditions:** When substance use is the underlying cause of another condition, document the causal relationship explicitly; casual link "Alcoholic cirrhosis" (K70.30) NOT separate "alcohol use + cirrhosis"
- **Confirm MEAT presence:** Each diagnosis should be supported within the record by evidence of monitoring, assessment, and active management during the calendar year, reflecting longitudinal care

Reframing Common Documentation Shortcuts

Instead of...	Prefer 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	8–24mg/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 Timing²²

- **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 the 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/ODD 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 Options²⁴

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 x 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 Clinical Review and Confirmation

Ensuring the medical record reflects current substance use disorder status

- **Annual review:** SUD diagnoses must be reassessed once per calendar year via face-to-face or video visit, with MEAT documented by 12/31.
- **Visit modality:** In-person or audio-video telehealth encounters qualify
- **Clinical context:** Under HCC V28, dependence/psychotic SUDs carry risk weight (≈0.484); uncomplicated use disorders do not; document current severity and status

Good Documentation is Comprehensive Coding

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

→ Increased documentation risk, potential RAF value decrease

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
SUD with complications	F10.1x, F11.1x	54	0	\$0

*Based on \$10,402.34 annual MA rate

REFERENCES

- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed, Text Rev. American Psychiatric Association Publishing; 2022. doi:10.1176/appi.books.9780890425787
- National Institute on Drug Abuse (NIDA). *Drugs, Brains, and Behavior: The Science of Addiction*. Revised July 2020. <https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction>.
- Centers for Disease Control and Prevention (CDC); National Center for Health Statistics. *ICD-10-CM Official Guidelines for Coding and Reporting, FY 2025*. Updated October 1, 2024. <https://icd10cmtool.cdc.gov>.
- Centers for Medicare & Medicaid Services (CMS). Risk Adjustment — Medicare Advantage: Model Information & Software (V28). Updated October 24, 2024. <https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment>.
- Centers for Medicare & Medicaid Services (CMS). *Risk Adjustment Model Version 28 Technical Specifications*. 2024. <https://www.cms.gov/files/document/v28-technical-specifications.pdf>.
- Li M, Peterson C, Xu L, Mikosz CA, Luo F. Medical Costs of Substance Use Disorders in the US Employer-Sponsored Insurance Population. *JAMA Netw Open*. 2023;6(1):e2252378. Published 2023 Jan 3. doi:10.1001/jamanetworkopen.2022.52378
- Centers for Disease Control and Prevention; National Center for Health Statistics. *Drug Overdose Deaths*. CDC; 2025. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>
- Avalere Health. *White Paper: The Cost of Opioid Use Disorder*. 2025. <https://advisory.avalerehealth.com/insights/white-paper-the-cost-of-opioid-use-disorder>.
- Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health*. HHS Publication No. PEP25-07-007 (NSDUH Series H-60). Published July 2025. <https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf>.
- National Institute on Alcohol Abuse and Alcoholism (NIAAA). *Alcohol and Aging*. Updated 2025. <https://www.niaaa.nih.gov/alcohols-effects-health/aging-and-alcohol>.
- American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2023 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults. *J Am Geriatr Soc*. 2023;71(4):e1-e28. doi:10.1111/jgs.18372
- Centers for Disease Control and Prevention. *Prescription Drug Monitoring Programs (PDMPs): Clinical Guidance*. Updated May 6, 2024.

- <https://www.cdc.gov/overdose-prevention/hcp/clinical-guidance/prescription-drug-monitoring-programs.html>.
13. National Institute on Drug Abuse (NIDA). *Prescription Opioids and Older Adults*. Updated 2025. <https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts>.
 14. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. *MMWR Recomm Rep*. 2022;71(3). doi:10.15585/mmwr.rr7103a1
 15. The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management. *J Addict Med*. 2020;14(3S Suppl 1). doi:10.1097/ADM.0000000000000668
 16. Substance Abuse and Mental Health Services Administration (SAMHSA). *Overdose Prevention and Response—Naloxone*. Updated 2024. <https://www.samhsa.gov/medications-substance-use-disorders/overdose-prevention>.
 17. Gould R, Lindenbaum L, Rogers WK. Anesthetic considerations for adults with substance use disorder or acute intoxication. In: Post TW, ed. *UpToDate*. Waltham, MA: UpToDate Inc. <https://www.uptodate.com/contents/anesthetic-considerations-for-adults-with-substance-use-disorder-or-acute-intoxication>
 18. American Society of Addiction Medicine. *Drug Abuse Screening Test (DAST-10)*. https://www.asam.org/docs/default-source/education-docs/drug-abuse-screening-test_dast10_8-28-2017.pdf.
 19. National Institute of Diabetes and Digestive and Kidney Diseases. *Chronic Pancreatitis—Symptoms & Causes*. Last reviewed 2017 . <https://www.niddk.nih.gov/health-information/digestive-diseases/pancreatitis/symptoms-causes#chronic>.
 20. Owens DK, Davidson KW, Krist AH, et al. Screening for Hepatitis C Virus Infection in Adolescents and Adults: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2020;323(10). doi:10.1001/jama.2020.1123
 21. American Society of Addiction Medicine. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 4th ed. ASAM; 2023. <https://www.asam.org/quality-care/the-asam-criteria>.
 22. Holt SR, Saxon AJ. Alcohol Use Disorder: Treatment Overview and Opioid Use Disorder: Treatment Overview. In: Post TW, ed. *UpToDate*. Literature review current through Sep 2025. Waltham, MA: UpToDate Inc. <https://www.uptodate.com/>.
 23. Sateia MJ, Buysse DJ, Krystal AD, Neubauer DN, Heald JL. Clinical Practice Guideline for the Pharmacologic Treatment of Chronic Insomnia in Adults: An American academy of sleep medicine clinical practice guideline. *J Clin Sleep Med*. 2017;13(2). doi:10.5664/jcsm.6470
 24. GoodRx. *Prescription Drug Prices*. GoodRx.com; 2024. <https://www.goodrx.com>.
 25. Centers for Medicare & Medicaid Services (CMS). *Hospital Readmissions Reduction Program (HRRP): Overview and Measures*. (Accessed 2025). <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program>.

Medical Disclaimer

The information provided by the American Academy of Value-Based Care (AAVBC) in this document, including but not limited to coding guidance, and related content, is intended for educational and informational purposes only. This content is designed to assist healthcare providers, organizations, and professionals in understanding and applying Value-Based Care principles, practices, and regulatory compliance standards.

AAVBC does not provide legal, clinical, or medical advice. The content presented should not be interpreted or relied upon as specific legal, medical, clinical, or professional guidance. While efforts are made to ensure the accuracy and currency of the information provided, AAVBC does not guarantee that the materials presented are complete, comprehensive, or without error.

Providers and healthcare professionals must independently evaluate all content and guidance presented herein in the context of applicable laws, regulations, clinical guidelines, payer policies, patient-specific conditions, and contraindications. Any treatments, procedures, diagnostic approaches, medications, or strategies discussed are illustrative and should not be directly applied without a thorough and independent review of current, evidence-based clinical resources, and regulatory requirements.

For coding, documentation, utilization management, quality measures (including STAR ratings), and compliance matters, users are responsible for consulting official guidelines issued by regulatory bodies, including but not limited to the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), relevant state agencies, and other authoritative entities.

AAVBC expressly disclaims liability for any loss, claim, or damages arising directly or indirectly from the use or reliance on information provided in this document. Users should consult their organization's legal counsel, compliance officer, or qualified professional advisor for advice specific to their situation.

By accessing and using this document, you agree to AAVBC's terms and acknowledge that the use of the content is at your own risk and discretion.