AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Sedative, Hypnotic and Anxiolytic Use Disorder

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Sedative, hypnotic, or anxiolytic use disorder (SHA-UD) is a substance use disorder defined by a problematic pattern of use of **benzodiazepines (BZDs)**, **Z-drugs** (zolpidem, eszopiclone, zaleplon), barbiturates, or **related GABAergic agents** that leads to clinically significant impairment or distress, manifested by at least **2 of 11 DSM-5-TR** criteria within a **12-month period**.[1] Chronic agonist exposure downregulates the GABA-A receptor, producing **physiological dependence, tolerance and a characteristic withdrawal syndrome**.[1,2] Benzodiazepine withdrawal is uniquely dangerous among common substance withdrawal syndromes. Abrupt cessation can precipitate **seizures, delirium, and death**, making medically supervised gradual tapering the standard of care rather than an option.[2] Because misuse in older adults is often a form of **self-treatment for chronic anxiety, insomnia, or pain**, person-first, **non-stigmatizing** framing is essential to therapeutic alliance.

ICD-10 Codes:

The **F13** family covers sedative, hypnotic, and anxiolytic-related disorders. DSM-5 eliminated the abuse/dependence split, but ICD-10-CM retains it: mild **SHA-UD** (2-3 criteria) maps to the **F13.1x** (abuse) series, while moderate (4-5 criteria) and severe (≥6 criteria) map to the **F13.2x** (dependence) series.[1] Complication subcodes carry the clinical detail: **F13.230** (dependence with withdrawal, uncomplicated), **F13.232** (withdrawal with perceptual disturbance), **F13.231** (withdrawal delirium), **F13.24** (induced anxiety disorder), **F13.27** (induced persisting dementia), **F13.280/F13.282** (induced anxiety/sleep disorder), and the **F13.x5x** series (induced psychotic disorder). Z-drugs belong in the **F13** series when use-disorder criteria are met — not **F51** or **G47.00** insomnia codes. Avoid **F13.10** (abuse, uncomplicated) and **F13.90** (unspecified, uncomplicated) when dependence or any complication is documentable — both carry no HCC weight. Use the in-remission codes **(F13.11/F13.21)** when a person previously met criteria but has ceased use and the diagnosis remains clinically relevant.[3]

Prevalence and Burden: Approximately **5.7 million** Americans aged **≥65** (roughly **10%** of the Medicare-eligible population) used **benzodiazepines** in 2023.[4] Among Medicare Part D enrollees, BZD prescriptions rose from **1.7 million to 3.1 million** (**+82%**) between 2017 and 2023, counter to the national decline.[5] Long-term use is the norm: **25-30%** of older adults taking BZDs do so longer than recommended.[4] Among adults ≥65 taking BZD or Z-drugs for ≥3 months, **45.3%** met DSM dependence criteria in a multicenter study (n=1,024).[6]

HCC/RAF V28 Mapping

ICD-10 CODE(S)[7]	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
F13.150–F13.159 (abuse); F13.250–F13.259 (dependance); F13.950–F13.959 (unspecified use pattern)	HCC 135 — Drug Use with Psychotic Complications	0.424	Document **hallucinations, delusions, or psychotic features** explicitly attributed to sedative/hypnotic use; specify delusions **(F13.x50)** vs. hallucinations **(F13.x51)** vs unspecified **(F13.x59)**

ICD-10 CODE(S)[7]	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
F13.20 (dependance; uncomplicated)/F13.21 (dependance, in remission)	HCC 137 — Drug Use Disorder, Moderate/ Severe, **or with** Non-Psychotic Complications	0.424	Document physiologic dependence with tolerance or withdrawal history; specify remission status and duration for **F13.21**
F13.220–F13.232 (dependence with intoxication or withdrawal	HCC 137 — Drug Use Disorder, Moderate/ Severe, or **with** Non-Psychotic Complications	0.424	Document the acute complication; specify delirium **(F13.221/F13.231)** or perceptual disturbance **(F13.232)** if present; note that withdrawal from this class is life-threatening
F13.24; F13.27; F13.280–F13.288 (dependence with induced mood disorder, persisting dementia, or other induced disorder [anxiety, sexual dysfunction, sleep disorder])	HCC 137 — Drug Use Disorder, Moderate/ Severe, **or with** Non-Psychotic Complications	0.424	Document the specific induced complication explicitly attributed to sedative/hypnotic dependence — not coded as a primary psychiatric diagnosis; for **F13.27**, distinguish from primary neurodegenerative dementia
F13.120–F13.139 (abuse with intoxication or withdrawal	HCC 137 — Drug Use Disorder, Moderate/ Severe, **or with** Non-Psychotic Complications	0.424	Document harmful use pattern without physiologic dependence; specify delirium **(F13.121/F13.131)** or perceptual disturbance **(F13.132)** if present
F13.14/F13.180–F13.188 (abuse; abuse with induced mood disorder or other induced disorder [anxiety, sexual dysfunction, sleep disorder])	HCC 137 — Drug Use Disorder, Moderate/ Severe, **or with** Non-Psychotic Complications	0.424	Document the specific complication and its explicit causal attribution to abuse; do not code as a standalone primary psychiatric diagnosis
F13.10 (abuse; uncomplicated)/F13.11 (abuse; in remission); F13.90 (use, unspecified; uncomplicated)/F13.91 (use, unspecified; in remission)	No HCC	—	**AVOID:** uncomplicated/ unspecified codes **do not risk-adjust**. When dependence features or any complication are present, documentation should support a higher-specificity **F13.2x** code

ICD-10 CODE(S)[7]	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT

ABBREVIATIONS: CMS-HCC V28 = Centers for Medicare & Medicaid Services Hierarchical Condition Category Model V28; CNA = Community Non-Dual Eligible, Aged segment; DSM-5-TR = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision; HCC = Hierarchical Condition Category; ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification; RAF = Risk Adjustment Factor; SHA-UD = sedative, hypnotic, or anxiolytic use disorder
***RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; 11 values vary across patient populations based on eligibility and care setting**

Risk-Adjusted Care Resources per Patient/Year[8]

Risk-adjusted care resource allocation — MA base rate (~$10,402.34) × RAF coefficient

Sedative, hypnotic, or anxiolytic use disorder (SHA-UD)

$4,411

HCC 135/137 · RAF 0.424

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

AAVBC PERSPECTIVE

*AAVBC encourages primary care providers to recognize sedative, hypnotic, or anxiolytic use disorder as a **neurobiological condition arising from GABA-A receptor downregulation** caused by chronic agonist exposure, not a behavioral failing or a consequence of poor patient decision-making. This distinction is clinically material: benzodiazepine and Z-drug withdrawal is a potentially fatal hyperexcitability syndrome that **requires structured, medically supervised tapering** rather than abrupt cessation.*

*AAVBC supports a shift in how prescription renewal encounters are conducted. Every benzodiazepine or Z-drug renewal is a **clinical opportunity** to evaluate tolerance, dose escalation, craving, and whether the patient is using the medication for purposes other than originally prescribed. Z-drugs including zolpidem, eszopiclone, and zaleplon meet use disorder criteria when those behavioral and physiological patterns are present, and should be clinically framed and managed accordingly.*

*AAVBC also encourages providers to **distinguish physiological dependence** arising from therapeutic use from the full **DSM-5 diagnostic criteria**, and to recognize that anxiety or insomnia driven by sedative withdrawal or chronic use represents a substance-induced disorder requiring a different clinical approach than a primary anxiety or sleep disorder. **This helps ensure the right patients are accurately identified, appropriately assessed, and guided toward the right treatment pathway.***

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings and Surveillance (Adult and Geriatric)

TEST/SERVICE	COVERAGE	FREQUENCY	CPT/ HCPCS	CLINICAL INDICATION
Two-question screen for BZD dependence (Voyer)[9]	Documented within E/M or AWV; no separate code	Annual wellness visit; every medication review	—	Ultra-brief: decreased medication effect? tried to stop? **Both affirmative = positive screen**; sensitivity **97%**, specificity **95%** in community-dwelling seniors
Severity of Dependence Scale (SDS)	Documented within E/M; no separate code	At screen-positive visit; periodically during taper	—	**5-item self-report** (0-15); cutoff **≥5.5 in adults ≥65** (AUC 0.86) detects dependence;[10] cutoff **>6 in general adults** (sensitivity 97.9%, specificity 94.2%)[11]
Annual alcohol misuse screening (SBIRT)	Medicare Part B preventive; no cost-sharing	Once per 12 months	G0442	**15-minute structured screen**; co-occurring alcohol use raises SHA-UD misuse risk (OR 2.3) and complicates withdrawal via GABA cross-tolerance[12]
Brief misuse counseling[13]	Medicare Part B preventive	Up to 4 sessions/ year for screen-positive patients	G0443	Brief intervention for patients screening positive for **substance misuse**
Structured substance-misuse assessment[14]	Medicare Part B; telehealth eligible	As indicated	G2011	Structured assessment when screening suggests a **use disorder**
Psychiatric diagnostic evaluation[15]	Medicare Part B	At initial SUD evaluation	90791/ 90792	Formal diagnostic evaluation; 90792 when medical services included
Annual depression screening[16]	Medicare Part B preventive	Once per 12 months	G0444	**Co-occurring depression is common and worsens with chronic BZD use**; distinguish primary from substance-induced

TEST/SERVICE	COVERAGE	FREQUENCY	CPT/ HCPCS	CLINICAL INDICATION
PDMP review[17]	Standard of care; not separately billable	Every visit (minimum q90 days)	—	Correlate patient-reported use with **dispensing data**; multiple prescribers may signal escalating use or diversion
Insomnia Severity Index (ISI)[18]	Documented within E/M	Baseline; q2-4 weeks during taper; post-taper	—	7-item (0-28) ≥15=**moderate insomnia** ≥8-point drop= **categorical improvement** <8= **remission** — tracks the indication that perpetuates use
GAD-7 (anxiety)[19]	Documented within E/M	Baseline; q2-4 weeks during taper	—	**7-item; ≥10 = moderate anxiety**. USPSTF recommends anxiety screening in adults but found insufficient evidence specifically in adults ≥65 — interpret with this caveat

ABBREVIATIONS: AUC = area under the curve; AWV = Annual Wellness Visit; BZD = benzodiazepine; CPT/HCPCS = Current Procedural Terminology/Healthcare Common Procedure Coding System; E/M = evaluation and management; GAD-7 = Generalized Anxiety Disorder 7-item scale; ISI = Insomnia Severity Index; PDMP = Prescription Drug Monitoring Program; SBIRT = Screening, Brief Intervention, and Referral to Treatment; SDS = Severity of Dependence Scale; SUD = substance use disorder; USPSTF = US Preventive Services Task Force

Subtle Early Signs in Older Adults (>65)

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Daytime sedation, unsteadiness, or new falls in a chronic BZD user	**Often misattributed to aging**; chronic use raises fall-related hospitalization (**HR 1.13**) and hip fracture (**HR 1.3**) — reassess the medication, not just the patient[20]
Subtle memory, attention, or word-finding decline	**BZD use is associated with dementia risk** (**OR 1.65**; **OR 2.81** for long half-life agents); deficits can persist after cessation — screen cognition rather than escalating sedatives[21]
Requests for early refills or dose increases for 'tolerance'[1]	**Tolerance and dose escalation** beyond the prescribed amount are DSM-5 criteria; a **refill encounter is a screening opportunity**, not a routine renewal
Rebound anxiety or insomnia between doses[2]	**Inter-dose withdrawal can masquerade as worsening of the original condition and drive escalation**; consider physiological dependence

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Using the medication for purposes or durations beyond what was intended[1]	**A core DSM-5 criterion**; in older adults this is frequently self-treatment for pain or sleep rather than recreational use — frame supportively
Quiet social withdrawal or reduced participation in valued activities[1]	Important activities given up or reduced is a DSM-5 criterion **easily missed in older adults living alone**
Slurred speech, ataxia, or fluctuating alertness at a routine visit[2]	**Suggests intoxication or excessive dosing** — assess for combined sedative-opioid-alcohol use and code the complication **(F13.x2x)**
Concern voiced by a caregiver about confusion or 'not being themselves'[22]	**Caregiver-reported change is a sensitive early signal** in older adults; engage the caregiver in the taper plan

ABBREVIATIONS: BZD = benzodiazepine; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; HR = hazard ratio; OR = odds ratio

Geriatric Risk Factors

FACTOR	RISK SIGNAL	NOTES
Age 60+ (vs. 18-29) for long-term use	**OR 7.1** (95% CI 2.4-20.8)[12]	**Older age is the dominant demographic risk factor** for transitioning to long-term BZD use
Age ≥85 (vs. 65-74) within an older cohort	**HR 1.48** for long-term BZD/Z-drug use[23]	Risk continues to **rise** across the geriatric range — the oldest-old are most exposed
Using medication for sleep	**OR 2.7** (95% CI 1.7-4.2) for long-term use[12]	The original insomnia indication strongly predicts chronicity; **pair taper with CBT-I**
Chronic physical illness	**OR 2.0** (95% CI 1.1-3.4)for long-term use[12]	Multimorbidity, common in Medicare populations, drives sustained use
Psychiatric comorbidity (any)[1]	**OR 2.22** for dependence[6]	**Anxiety, depression, and insomnia** are indications for and complications of sedative use
Comorbid agoraphobia	**OR 2.0** (95% CI 1.3-3.1) for long-term use[12]	Anxiety-spectrum disorders **raise** the likelihood of long-term use
Concurrent alcohol use disorder[6]	**OR 2.3** (95% CI 1.7-3.1) for misuse[12]	GABA cross-tolerance complicates withdrawal; screen and code separately **(F10.x)**

FACTOR	RISK SIGNAL	NOTES
Concurrent prescription opioid use disorder	**OR 4.8** (95% CI 3.5-6.7) for misuse[12]	Highest-magnitude substance comorbidity; FDA Boxed Warning for combined respiratory depression
Living alone	**OR 1.45**[6]	**Social isolation**, frequent in older adults, modestly elevates dependence risk
Significant relationship difficulties	**OR 1.96**[6]	**Psychosocial stressors** contribute to sustained use
Transgressional behavior to procure BZD	**OR 2.70**[6]	Seeking from multiple providers or sources signals escalating use disorder
Concurrent SSRI use	**OR 1.7** (95% CI 1.1-2.7) for long-term use[12]	**Co-prescribing** for anxiety may anchor sustained BZD use; optimize the antidepressant

ABBREVIATIONS: BZD = benzodiazepine; CBT-I = cognitive behavioral therapy for insomnia; CI = confidence interval; GABA = gamma-aminobutyric acid; HR = hazard ratio; OR = odds ratio; SSRI = selective serotonin reuptake inhibitor

Diagnostic Thresholds (DSM-5-TR)

SYSTEM/CRITERION	DIAGNOSTIC THRESHOLD	NOTES
DSM-5-TR diagnosis (APA 2022)	**≥2 of 11 criteria within 12 months**: larger amounts/longer than intended; unsuccessful efforts to cut down; time spent obtaining/using/recovering; craving; failure of role obligations; social/interpersonal problems; activities given up; hazardous use; use despite known harm; tolerance; withdrawal[1]	**Tolerance and withdrawal occurring solely within appropriate medical use do not count** unless other criteria (e.g., dose escalation beyond prescribed, multi-provider sourcing) are also met
DSM-5-TR severity → ICD-10 mapping	**Mild** = 2-3 criteria **Moderate**=4-5 (dependence) **Severe**= ≥6 (dependence)[1]	**Severity informs treatment intensity**; mild SUD may respond to brief intervention and outpatient counseling; moderate-to-severe SUD typically warrants structured treatment and pharmacotherapy evaluation

SYSTEM/CRITERION	DIAGNOSTIC THRESHOLD	NOTES
Severity of Dependence Scale (SDS)	**Adults ≥65: cutoff 5.5**, AUC 0.86 (95% CI 0.79-0.93) **General adults: cutoff >6**, sensitivity 97.9%, specificity 94.2%, AUC 0.991[10,11]	**Best-validated brief screen**; validated against DSM-IV criteria (interpret with DSM-5-TR judgment)
Two-question screen (Voyer)	Decreased medication effect? Tried to stop? **Both affirmative = positive** (sensitivity 97%, specificity 95%)[9]	**No materials, scoring, or training needed**; ideal for primary care workflow
Insomnia Severity Index (ISI)	0-28; ≥15 = moderate; ≥8-point drop = categorical improvement; <8 = remission[18]	Tracks the sleep indication that perpetuates use; **slightly lower validity in adults ≥65**[24]
GAD-7 (anxiety)	≥10 = moderate anxiety; pooled sensitivity 0.79, specificity 0.89 at cutoff ≥10[19,25]	USPSTF found insufficient evidence to recommend anxiety screening specifically in adults ≥65 — best available tool, interpret accordingly
BZD withdrawal monitoring	No validated scale exists; ACMT/ASAM recommends structured symptom checklist plus vital signs[17]	Unlike alcohol (CIWA-Ar), **BZD withdrawal lacks a robustly validated instrument** — CIWA-B and BWSQ have limited validation

ABBREVIATIONS: ACMT = American College of Medical Toxicology; APA = American Psychiatric Association; ASAM = American Society of Addiction Medicine; AUC = area under the curve; BWSQ = Benzodiazepine Withdrawal Symptom Questionnaire; BZD = benzodiazepine; CI = confidence interval; CIWA-Ar = Clinical Institute Withdrawal Assessment for Alcohol, revised; CIWA-B = Clinical Institute Withdrawal Assessment - Benzodiazepines; DSM-5-TR = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision; GAD-7 = Generalized Anxiety Disorder 7-item scale; ICD-10 = International Classification of Diseases, 10th Revision; ISI = Insomnia Severity Index; SDS = Severity of Dependence Scale; USPSTF = US Preventive Services Task Force

Clues to Dig Deeper

CLINICAL CLUE	WHY IT MATTERS	NEXT DIAGNOSTIC STEP
Long-term daily BZD or Z-drug use with no documented indication	The indication is undetermined in **57%** of primary care charts; long-term use itself warrants reassessment[26]	Administer the **two-question screen or SDS**; document the pattern of use and the original indication
Requests for early refills or self-reported dose escalation[1]	Tolerance and using more than intended are DSM-5 criteria pointing to dependence **(F13.2x)**	**Count DSM-5 criteria**; correlate report with PDMP; consider urine drug screen

CLINICAL CLUE	WHY IT MATTERS	NEXT DIAGNOSTIC STEP
Z-drug use (zolpidem, eszopiclone, zaleplon) with loss of control[1]	Z-drugs are frequently miscoded as insomnia **(F51/G47.00)** even when use-disorder criteria are me	**Count DSM-5 use-disorder criteria**; address underlying insomnia with CBT-I; initiate a supervised taper if ≥2 criteria are met
New or worsening anxiety, insomnia, or low mood in a chronic user[2]	May be **substance-induced** rather than a primary disorder — distinguishing the two changes the code and the plan	**Assess symptom onset relative to dose changes**; hold or taper the BZD; refer for psychiatric evaluation if symptoms persist after discontinuation
Co-prescribed opioid or active alcohol use[17]	Combined use sharply raises respiratory-depression and overdose risk **(concurrent BZD in 70% of opioid overdose deaths)**	**Screen for alcohol** (AUDIT-C) and opioid use; consider naloxone
Unsteady gait, recurrent falls, or a new fracture[20]	Chronic BZD use **elevates falls and hip-fracture risk** independent of dose	**Document BZD as a contributing factor**; code the fall/fracture alongside SHA-UD; initiate fall-risk assessment
Documented dementia or falls history with a continued BZD[27]	Triggers HEDIS Drug-Disease Interaction measures and worsens cognition	**Initiate a deprescribing plan**; document alternatives tried; the taper itself improves the quality measure

ABBREVIATIONS: AUDIT-C = Alcohol Use Disorders Identification Test - Consumption; BZD = benzodiazepine; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; HEDIS = Healthcare Effectiveness Data and Information Set; PDMP = Prescription Drug Monitoring Program; SDS = Severity of Dependence Scale; SHA-UD = sedative, hypnotic, or anxiolytic use disorder

Common Oversights

OVERSIGHT/SHORTCUT	WHY IT MATTERS - WHAT TO DO INSTEAD
Treating a refill visit as a renewal rather than a screening opportunity	**PCPs write ~90% of new BZD prescriptions**; the encounter is the principal point to detect a use disorder. Screen with the two-question tool or SDS and correlate with PDMP at every refill[28]
Missing induced anxiety and sleep disorders[1]	**Sedative-induced anxiety and sleep disorders** are frequently present but **undocumented**; identifying them distinguishes substance-induced from primary psychiatric disorders and guides the treatment plan

OVERSIGHT/SHORTCUT	WHY IT MATTERS - WHAT TO DO INSTEAD
Omitting withdrawal specificity[1]	**Uncomplicated withdrawal** and **withdrawal with perceptual disturbance** represent clinically distinct severities with different monitoring and intervention needs; document the specific signs present at each encounter
Documenting tolerance/withdrawal from appropriate medical use as a use disorder[1]	Tolerance and withdrawal in correctly prescribed use **do not count toward DSM-5 criteria** unless other criteria (dose escalation, multi-provider sourcing) are also met
Attempting abrupt discontinuation[2]	**Abrupt cessation** can precipitate **seizures and delirium**, especially **above 10 mg diazepam-equivalent daily**. Use a supervised gradual taper
Using stigmatizing language ('addict,' 'drug-seeker,' 'non-compliant')[17]	**Moralistic framing** undermines therapeutic alliance and violates dignity-first standards. Use 'person with a sedative use disorder' or 'physiological dependence on a benzodiazepine'
Assuming low dose means low risk in older adults[27]	Even low BZD doses carry meaningful fall, fracture, and cognitive risk in adults ≥65; AGS Beers lists all BZDs/Z-drugs as potentially inappropriate

ABBREVIATIONS: AGS = American Geriatrics Society; BZD = benzodiazepine; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; HCC = Hierarchical Condition Category; PCP = primary care provider; PDMP = Prescription Drug Monitoring Program; SDS = Severity of Dependence Scale

Key Differentials in Elderly

PRESENTATION	DIFFERENTIAL	KEY TESTS/STEPS
Daytime sedation and unsteadiness in a chronic user[17]	BZD/Z-drug effect vs primary neurodegenerative disease vs metabolic/electrolyte disturbance vs polypharmacy sedation vs depression	**Medication review and PDMP**; cognitive screen (MoCA/ MMSE); Timed Up and Go; consider taper before attributing to aging
New or worsening anxiety in a chronic user[1]	Substance-induced anxiety **(F13.280/F13.24)** vs inter-dose withdrawal vs primary generalized anxiety disorder vs hyperthyroidism	**GAD-7**; assess symptom timing relative to dosing; TSH; code induced vs. primary appropriately
Persistent insomnia despite nightly hypnotic[29]	Substance-induced sleep disorder **(F13.282/F13.182)** vs tolerance vs primary insomnia vs sleep apnea vs depression	**ISI**; sleep history; consider sleep study; pair taper with CBT-I

PRESENTATION	DIFFERENTIAL	KEY TESTS/STEPS
Confusion or agitation in an older adult[30]	Sedative intoxication or withdrawal delirium **(F13.231)** vs infection/ delirium from other cause vs dementia vs metabolic encephalopathy	**Vital signs and mental-status exam**; review recent dose changes; rule out other delirium causes; urgent evaluation if autonomic instability
Recurrent falls or a new fracture[17]	BZD-related psychomotor impairment vs orthostasis vs vestibular/ neurologic disease vs vision impairment vs environmental hazards	**Medication review**; gait assessment; orthostatic vitals; document BZD as contributing factor
Cognitive decline during or after BZD use[21]	Substance-induced persisting dementia **(F13.27)** vs Alzheimer or other neurodegenerative dementia vs depression-related pseudodementia	**Cognitive testing**; geriatric assessment; reassess after taper

ABBREVIATIONS: BZD = benzodiazepine; CBT-I = cognitive behavioral therapy for insomnia; GAD-7 = Generalized Anxiety Disorder 7-item scale; ISI = Insomnia Severity Index; MMSE = Mini-Mental State Examination; MoCA = Montreal Cognitive Assessment; PDMP = Prescription Drug Monitoring Program; TSH = thyroid-stimulating hormone

Comorbidity Screening

CONDITION	PREVALENCE/ASSOCIATION	SCREENING APPROACH
Falls and fractures (W19.x, S72.x)[20]	Chronic vs. intermittent BZD use: fall-related hospitalization **HR 1.13**; hip fracture **HR 1.3**	**Fall-risk assessment at every encounter**; document BZD as a contributing factor
Cognitive impairment and dementia (G30.x, F03.x)[21]	**BZD use associated with dementia** (OR 1.65; OR 2.81 for long half-life agents); deficits can persist post-cessation	**MoCA/MMSE at baseline and periodically**; HEDIS DAE-Dementia applies
Opioid co-use (F11.x)[17]	Concurrent BZD present in **~70%** of opioid overdose deaths; combined use elevates respiratory depression and mortality	**PDMP**; assess for OUD; FDA Boxed Warning applies; consider naloxone
Alcohol use disorder (F10.x)[12]	Co-occurring AUD raises misuse risk **(OR 2.3)**; GABA cross-tolerance complicates withdrawal	AUDIT-C or CAGE at every encounter

CONDITION	PREVALENCE/ASSOCIATION	SCREENING APPROACH
Depression (F32.x, F33.x)[2]	**Chronic BZD use can w**orsen depressive symptoms via reduced GABAergic/serotonergic function	**PHQ-9**; optimize antidepressant before or during taper; distinguish primary from substance-induced
Co-occurring anxiety/insomnia[6]	**Psychiatric comorbidity OR 2.22** for dependence; these are both indications and complications	**GAD-7**, ISI; treat with non-BZD evidence-based therapy
Chronic pain[17]	Older adults often use BZDs as self-treatment for pain — a different driver than recreational misuse	**Address pain with non-sedative alternatives**; frame the taper as helping, not punishing

ABBREVIATIONS: AUD = alcohol use disorder; AUDIT-C = Alcohol Use Disorders Identification Test - Consumption; BZD = benzodiazepine; CAGE = Cut down, Annoyed, Guilty, Eye-opener screen; DAE = Avoidance of Drug-Disease Interactions in the Elderly (HEDIS); GABA = gamma-aminobutyric acid; GAD-7 = Generalized Anxiety Disorder 7-item scale; HEDIS = Healthcare Effectiveness Data and Information Set; ISI = Insomnia Severity Index; MMSE = Mini-Mental State Examination; MoCA = Montreal Cognitive Assessment; OUD = opioid use disorder; OR = odds ratio; PDMP = Prescription Drug Monitoring Program; PHQ-9 = Patient Health Questionnaire-9

⚠ RED FLAG — EMERGENCY/ACTIVATE CRISIS RESPONSE

These emergency conditions require same-day ED transfer or emergent consultation:

- **Withdrawal seizure** (grand mal onset; risk increases above 10 mg diazepam-equivalent daily or with abrupt cessation)
  → Emergent medical management; IV benzodiazepine protocol; continuous monitoring; do not attempt outpatient stabilization
  ✕ Potentially fatal without immediate intervention; risk is dose- and duration-dependent
- **Withdrawal delirium** (confusion, agitation, hallucinations, autonomic instability)
  → Inpatient admission; parenteral benzodiazepine management; continuous vital sign monitoring
  ✕ Untreated delirium carries significant mortality; autonomic instability can escalate rapidly without inpatient control
- **Suspected overdose, particularly with co-ingested opioids or alcohol** (altered consciousness, respiratory depression)
  → ED transfer; naloxone for opioid co-ingestion; airway support; toxicology consultation
  ✕ Concurrent BZD use is present in approximately 70% of opioid overdose deaths; BZDs potentiate opioid-induced respiratory depression
- **Acute suicidality in the context of intoxication or withdrawal**
  → Emergent psychiatric evaluation; activate crisis response; do not discharge
  ✕ Intoxication and withdrawal both markedly elevate impulsivity and suicide risk

⚠ RED FLAG — URGENT (24-72 HOURS)

These conditions require urgent evaluation and management within 24–72 hours:

- **Withdrawal with perceptual disturbance** (hallucinations with intact reality testing; visual or auditory illusions)
  → Reassess and slow the taper; arrange urgent medical evaluation; consider inpatient escalation
  ✕ Indicates severe withdrawal progression; can evolve to full delirium without intervention
- **Paranoid ideation or psychotic symptoms during withdrawal or active use**
  → Urgent psychiatric assessment to differentiate substance-induced psychosis from a primary psychotic disorder
  ✕ Failure to distinguish etiology leads to inappropriate treatment or a missed primary psychiatric diagnosis
- **Autonomic instability during taper** (heart rate >100 bpm, diaphoresis, hypertension)
  → Pause the taper; arrange urgent medical evaluation; reassess the dosing schedule
  ✕ Indicates taper is proceeding too rapidly; unchecked instability can escalate to seizure or delirium
- **History of prior withdrawal seizures in a patient currently tapering**
  → Slow or pause the taper; consider inpatient or medically supervised setting
  ✕ Prior seizure history is the strongest predictor of recurrent withdrawal seizure
- **Suspected diversion or transactional behavior to obtain sedatives** (lost prescriptions, multi-provider sourcing, escalating requests)
  → Refer for formal SUD assessment; review PDMP; establish a single-prescriber agreement
  ✕ Diversion patterns signal loss of control and escalating use-disorder severity

3 MEAT DOCUMENTATION ESSENTIALS

SHA-UD documentation is critical to support **continuity, quality measurement, and safe deprescribing** for patients. The most common gaps are failing to document the DSM-5 criterion count that distinguishes mild from **moderate or severe** disorder, **omitting withdrawal** and **induced-disorder complications** that are clinically present, **miscoding Z-drug use disorder as insomnia**, and **missing documentation of the original indication and prior tapering attempts**. Each gap obscures the person's real clinical complexity and impedes the shared decision-making that makes a taper succeed.

Case vignette: A 74-year-old man is seen for a routine refill of lorazepam 1 mg three times daily, prescribed for anxiety and sleep for the past 9 years. He reports the medication 'doesn't work like it used to' and that an attempt to stop last year caused shakiness and a sleepless week. He has had two near-falls in the past 3 months. He lives alone. PDMP shows a single prescriber and consistent fills. Functional status: independent in ADLs; recent ISI 18; GAD-7 11; Timed Up and Go 13 seconds.

MONITOR: Long-term lorazepam use (**9 years**, **1 mg three times daily**); patient-reported tolerance (reduced effect over time) and prior unsuccessful cessation attempt with withdrawal symptoms — **2** DSM-5 criteria already met. Near-falls: **2 in the past 3 months**. **Timed Up and Go: 13 seconds** (threshold

>**12 s** = elevated fall risk). **ISI: 18** (moderate-severe insomnia); **GAD-7: 11** (moderate anxiety) — both track the original indications perpetuating use. **Lives alone**; independent in ADLs.

EVALUATE: **Two-question screen: both affirmative** — positive. DSM-5 criterion count: tolerance confirmed, withdrawal on cessation confirmed, unsuccessful effort to cut down confirmed, use longer than intended — **≥3 criteria**, at least moderate severity. PDMP: single prescriber, consistent fills — no diversion signal. SDS administered to quantify dependence severity. AUDIT-C administered; opioid co-prescribing assessed given elevated combined-use risk.

ASSESS: Sedative, hypnotic, or anxiolytic dependence, **moderate severity**, with physiological dependence (tolerance and prior withdrawal); criterion count documented explicitly. Elevated fall risk: Timed Up and Go **13 seconds**. Moderate insomnia (**ISI 18**) and moderate anxiety (**GAD-7 11**) represent the original indications — reassess after taper to distinguish primary disorder from substance-induced contributions. Lives alone: heightens monitoring needs throughout the taper.

TREAT: Shared decision-making initiated; **gradual supervised taper** per ACMT/ASAM Joint CPG — **no abrupt discontinuation given seizure risk**. Reduce by approximately **20%** per week; reassess **1–2 weeks** after each step; slow the pace at the lower end of the taper. CBT-I initiated concurrently — in adults **≥65** tapering for sleep, CBT plus taper achieved discontinuation in **70%** vs. **24%** with taper alone (NNT **2**). Anticipatory guidance provided: mild rebound anxiety and insomnia are common and usually transient; seizures and delirium are rare with a supervised schedule. Follow-up within **14 days**. Plan documented in person-first language.

Clinical Documentation Elements

- **Document the DSM-5 criterion count explicitly** (which of the 11 criteria are met) to justify mild **(F13.1x)** vs. moderate/severe **(F13.2x)** severity — severity drives the documentation hierarchy
- **Document physiological features in specific language:** 'tolerance to benzodiazepine effects,' 'withdrawal symptoms upon dose reduction,' or 'meets ≥4 DSM-5 criteria for SHA-UD'[1] — these phrases support **F13.2x** dependence coding
- **Document specific complications and code them:** withdrawal **(F13.230)**, withdrawal with perceptual disturbance **(F13.232)**, induced anxiety **(F13.280/F13.24)**, induced sleep disorder **(F13.282)**, induced persisting dementia **(F13.27)**
- **Document the substance class and that Z-drugs** (zolpidem, eszopiclone, zaleplon) are coded in the **F13** series when use-disorder criteria are met — not as insomnia
- **Document the indication for long-term use and any prior tapering attempts** — both are frequently missing and are central to defining severity and the care plan
- **Document co-occurring substance use separately:** alcohol **(F10.x)** and opioid **(F11.x)** use disorders, given cross-tolerance and combined respiratory-depression risk
- **Document the comorbidity burden affecting the plan:** falls/fractures, cognitive status, depression and anxiety, chronic pain, and polypharmacy
- **Use person-first, non-stigmatizing language throughout:** 'a person with a sedative use disorder,' 'physiological dependence on a benzodiazepine' — never 'addict,' 'abuser,' 'clean/dirty,' or 'non-compliant'

Reframing Common Documentation Shortcuts

INSTEAD OF...	DOCUMENT...
'Benzo abuse'/'Xanax addiction'	'Sedative, hypnotic, or anxiolytic dependence, moderate **(F13.20)** — meets 4 DSM-5 criteria including tolerance and withdrawal; person-first plan for supervised taper'
'Long-term lorazepam, refill given'	'Long-term lorazepam (9 y) for anxiety/insomnia; two-question screen positive; tolerance and prior withdrawal documented **(F13.20)**; shared-decision taper initiated'
'Patient withdrawing'	'Sedative dependence with withdrawal, uncomplicated **(F13.230)** — tremor and insomnia 5 days after dose reduction; taper paused and slowed'
'Anxiety, on alprazolam'	'Sedative-induced anxiety disorder **(F13.280)** — anxiety emerges in the inter-dose interval; distinguished from primary GAD; non-BZD anxiolytic and CBT begun'
'Insomnia, continue zolpidem'	'Z-drug (zolpidem) use disorder, moderate **(F13.20)** — loss of control and dose escalation meet ≥4 DSM-5 criteria; coded in **F13** series, not as insomnia; CBT-I initiated'
'Dementia, on diazepam'	'Sedative-induced persisting cognitive impairment **(F13.27)** vs. neurodegenerative dementia under evaluation; BZD deprescribing initiated; HEDIS DAE-Dementia addressed'
'In remission'	'Sedative dependence, in remission **(F13.21)** — previously met ≥4 DSM-5 criteria; no use ×6 months; diagnosis remains clinically relevant for surveillance'
'Non-compliant with taper'	'Taper paused at patient request after rebound anxiety; anticipatory guidance reinforced; pace renegotiated through shared decision-making'
'Drug-seeking, multiple refills'	'Early-refill requests and patient-reported dose escalation (tolerance, using more than intended) — DSM-5 criteria for dependence; PDMP correlated'
'Sedative use, unspecified'	'Sedative dependence with withdrawal and induced sleep disorder **(F13.230 + F13.282)'** — specific complications documented'

ABBREVIATIONS: BZD = benzodiazepine; CBT = cognitive behavioral therapy; CBT-I = cognitive behavioral therapy for insomnia; DAE = Avoidance of Drug-Disease Interactions in the Elderly (HEDIS); DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; GAD = generalized anxiety disorder; HCC = Hierarchical Condition Category; HEDIS = Healthcare Effectiveness Data and Information Set; PDMP = Prescription Drug Monitoring Program

DOCUMENTATION IS COMPREHENSIVE CODING

At each SHA-UD encounter, document DSM-5 criterion count and severity, and specify the physiological features present (such as tolerance and withdrawal). Complications require the correct subcode: withdrawal **(F13.230/F13.232)**, induced anxiety **(F13.280/F13.24)**, induced sleep disorder **(F13.282)**, and induced dementia **(F13.27)**. Also document the substance class, including Z-drugs within the **F13** series, the clinical indication, and prior tapering attempts. Co-occurring alcohol and opioid use disorders are coded separately and the full comorbidity burden (falls, cognitive impairment, depression or anxiety, and polypharmacy) should be documented using non-stigmatizing clinical language.

4 TREATMENT AND REFERRAL QUICK GUIDE

Management of sedative, hypnotic, and anxiolytic use disorders (SHA-UD) is anchored in **gradual supervised** dose tapering combined with **non-pharmacological treatment of the underlying anxiety or insomnia. No FDA-approved medications specific to SHA-UD exist.** The current US framework is the **2024/2025 Joint ACMT/ASAM Clinical Practice Guideline on Benzodiazepine Tapering; the VA/DoD SUD Guideline (2021)** provides taper schedules, and the **AGS Beers Criteria (2023)** list all BZDs and Z-drugs as potentially inappropriate in adults ≥65. The PCP's highest-value contributions are recognizing the disorder at refill and wellness visits, staging severity by DSM-5 criteria, initiating an individualized taper with concurrent CBT, monitoring for withdrawal, and coordinating deprescribing across transitions of care. **Tapering is always calibrated and individualized**, and **never abrupt**, because withdrawal can be life-threatening.

Therapy Escalation Criteria

TRIGGER	ACTION
Positive two-question screen or SDS ≥5.5 (adults ≥65)[12]	**Count DSM-5 criteria**;establish severity; correlate with PDMP; begin shared-decision taper planning
≥4 DSM-5 criteria, tolerance, or withdrawal documented[17]	**Diagnose dependence**; initiate gradual supervised taper; do not attempt abrupt cessation
Low-dose user beginning a taper[31]	Reduce **~20% per week** with reassessment 1-2 weeks after each reduction; dose reductions of 5-15% may be needed at the lower end
Higher-dose user beginning a taper[31]	Weekly **25% reduction until 50% of dose remains**, then one-eighth reductions every 4-7 days; total 8-12 weeks (longer if needed)

TRIGGER	ACTION
Persistent anxiety or insomnia perpetuating use[33]	Begin **CBT/CBT-I** concurrently (first-line per AGS Beers companion); CBT + taper achieved **70% vs. 24%** discontinuation (NNT 2)
Refractory withdrawal symptoms despite slowing the taper[34]	**No single adjunctive medication is routinely recommended**; **slow the taper further**; consider case-by-case options with caution
Insomnia during taper[35]	**Do not substitute Z-drugs** (same receptor action); consider melatonin or trazodone as non-GABAergic options
New SHA-UD (F13) diagnosis[36]	**Schedule a follow-up or treatment service within 14 days** (HEDIS IET Initiation) and two more within 34 days (Engagement)
History of withdrawal seizures or delirium[17]	**Refer to addiction medicine or psychiatry**; consider inpatient/medically managed withdrawal
Failed ≥2 outpatient taper attempts[34]	**Refer for structured withdrawal management**; reassess severity and co-occurring disorders
Concurrent opioid or alcohol use disorder[17]	**Coordinate integrated treatment**; do not discontinue established OUD medications (buprenorphine/methadone) for the BZD taper
Peri-hospitalization/transition of care[26]	**Coordinate with inpatient teams to avoid inadvertent BZD reinitiation at discharge** — a high-value VBC intervention point

ABBREVIATIONS: ACMT = American College of Medical Toxicology; AGS = American Geriatrics Society; ASAM = American Society of Addiction Medicine; BZD = benzodiazepine; CBT = cognitive behavioral therapy; CBT-I = cognitive behavioral therapy for insomnia; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; IET = Initiation and Engagement of SUD Treatment (HEDIS); NNT = number needed to treat; OUD = opioid use disorder; PDMP = Prescription Drug Monitoring Program; SDS = Severity of Dependence Scale; VBC = value-based care

ACMT/ASAM 2024–2025 and VA/DoD 2021-Aligned Deprescribing Pathway

STEP/SETTING	RECOMMENDED PATHWAY (ACMT/ASAM 2024-2025; VA/DOD 2021)	KEY NOTES
Step 1 — Assessment and stabilization (primary care)[17]	Medication reconciliation, PDMP review, urine drug screen; establish DSM-5 severity; treat co-occurring anxiety/insomnia/depression with non-BZD therapy; consider consolidating multiple short-acting BZDs to one agent before taper	**Geriatric-specific**: metabolic changes increase BZD sensitivity — **start with smaller reductions and proceed more slowly**. Switching to a long-acting agent is widely practiced but expert-opinion based, not RCT-proven
Step 2 — Gradual taper, low-dose user[31]	Reduce **10–25% per adjustment** step; allow 2–4 weeks between reductions; drop to **5–15%** steps at the lower end of the dose; **reassess** 1–2 weeks after each change.	**Slow tapering achieves complete cessation in approximately two-thirds of patients**; flexibility is essential
Step 2 — Gradual taper, higher-dose user[31]	Weekly **25% reduction until 50% of dose remains**, then one-eighth dose reduction every 4-7 days; total taper 8-12 weeks, up to 6 months or longer in complex cases[32]	Even low residual doses may carry withdrawal risk in older adults; individualize through shared decision-making
Concurrent behavioral therapy[33]	**CBT/CBT-I delivered alongside the taper** (first-line per AGS Beers companion); digital CBT-I (e.g., VA Insomnia Coach) where access is limited	**CBT + taper 70% vs. 24% discontinuation** (NNT 2); masked taper + augmented CBT-I 73.4% vs. 58.6%; benefit at 3 months (RR 1.51, 95% CI 1.15-1.98), attenuating by 6 months[37]
Direct-to-patient education[38]	Self-guided CBT-I booklets and anticipatory guidance (YAWNS NB model)	Mailed self-guided booklets achieved discontinuation or **≥25%** dose reduction in 46.6% vs. 20.3% usual care (P<.001); patient education adds ~144 more discontinuations per 1,000
Pharmacist-led intervention	Pharmacist-guided taper with brief CBT, integrated into primary care[2]	Largest point estimate in the 2025 BMJ meta-analysis — **491 more discontinuations per 1,000 vs. usual care**; a virtual pilot achieved a mean 60.5% dose reduction (95% CI 51.3-69.9%) in adults ≥65[39,40]

STEP/SETTING	RECOMMENDED PATHWAY (ACMT/ASAM 2024-2025; VA/DOD 2021)	KEY NOTES
Step 3 — Adjunctive pharmacotherapy (only if taper alone insufficient)[17]	**No single agent is routinely recommended**; primary strategy is to slow the taper. Case-by-case, low-quality-evidence options only	Carbamazepine, pregabalin, paroxetine, imipramine considered selectively; gabapentinoids carry misuse/fall risk; **flumazenil NOT recommended** (can precipitate severe withdrawal)
Step 4 — Specialist referral/higher level of care[34]	Addiction medicine or psychiatry for withdrawal seizures/delirium, failed ≥2 outpatient tapers, severe co-occurring psychiatric disorders, or concurrent opioid/alcohol use disorder; inpatient/residential for severe acute withdrawal	**Do not discontinue established OUD medications** (buprenorphine/methadone) for the BZD taper
Transitions of care[26]	**Coordinate deprescribing** across the peri-hospitalization period to avoid inadvertent BZD reinitiation at discharge	A high-value VBC intervention point that standard guidelines underemphasize

ABBREVIATIONS: ACMT = American College of Medical Toxicology; AGS = American Geriatrics Society; ASAM = American Society of Addiction Medicine; BZD = benzodiazepine; CBT = cognitive behavioral therapy; CBT-I = cognitive behavioral therapy for insomnia; CI = confidence interval; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; NNT = number needed to treat; OUD = opioid use disorder; PDMP = Prescription Drug Monitoring Program; RR = risk ratio; VBC = value-based care

CLINICAL PEARL: DOSE REDUCTION

There is no single tapering schedule that fits every patient. **Dose reductions must be individualized and adjusted based on clinical response**. Abrupt cessation can precipitate seizures, delirium, and death, particularly above 10 mg diazepam-equivalent daily, whereas a gradual, individualized taper achieves complete cessation in approximately two-thirds of patients. Patients frequently underestimate their own intake, therefore actual physiologic tolerance should be assessed before establishing the starting taper dose. The taper rarely succeeds in isolation: pairing it with CBT or CBT-I roughly triples discontinuation rates (70% vs. 24%, NNT 2)[6] by addressing the anxiety or insomnia perpetuating use. Patient-directed pacing within a safe clinical window is appropriate, and shared decision-making is the strongest predictor of a successful taper.

Benzodiazepine Dose Equivalency Reference*

BENZODIAZEPINE	ATC CLASS	VA/DOD SUD CPG (2021)[31]	ASHTON MANUAL (2002)[41]
Alprazolam	Anxiolytic	1 mg	0.5 mg
Chlordiazepoxide	Anxiolytic	25 mg	25 mg
Clonazepam	Antiepileptic	1 mg	0.5 mg
Clorazepate	Anxiolytic	15 mg	15 mg
Diazepam	Anxiolytic	10 mg	10 mg
Estazolam	Sedative-hypnotic	1 mg	1–2 mg
Flurazepam	Sedative-hypnotic	15 mg	15–30 mg
Lorazepam	Anxiolytic	2 mg	1 mg
Oxazepam	Anxiolytic	30 mg	20 mg
Quazepam	Sedative-hypnotic	10 mg	20 mg
Temazepam	Sedative-hypnotic	15 mg	20 mg
Triazolam	Sedative-hypnotic	0.25 mg	0.5 mg

ABBREVIATIONS: ATC = Anatomical Therapeutic Chemical classification system; CPG = clinical practice guideline; DoD = US Department of Defense; SUD = substance use disorder; VA = US Department of Veterans Affairs
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	TARGET/RECOMMENDATION	NOTES
CBT/CBT-I[35]	**First-line** for the underlying insomnia or anxiety; delivered concurrently with the taper	Strongest evidence base; CBT + taper **70% vs. 24%** discontinuation (NNT 2); sleep hygiene alone is insufficient for chronic insomnia
Digital CBT-I platforms[35]	**VA Insomnia Coach**, SleepEZ, or equivalent where in-person access is limited	Address the access barrier common in Medicare populations; deliver comparable benefit

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Self-guided CBT-I education (YAWNS NB model)[38]	Mailed or distributed self-guided booklets with anticipatory withdrawal guidance	**46.6% discontinuation/dose reduction vs. 20.3% usual care** (P<.001); scalable and low-cost
Structured medication review[39]	Comprehensive reconciliation as part of routine geriatric care	Adds **~104 more discontinuations per 1,000 vs. usual care**; already standard in VBC settings
Anticipatory guidance on withdrawal[42]	Counsel that **mild rebound** anxiety/insomnia is common and usually transient **(2-4 weeks)**; severe events (seizures, delirium) are rare; deprescribing in adults ≥65 is generally safe with typically mild, transient withdrawal	Reduces alarm and improves taper adherence; **reassess 1-2 weeks after each reduction**
Sleep hygiene and stimulus control[35]	Consistent schedule, stimulus control, sleep restriction — components of CBT-I	Maintain benefit after discontinuation; insufficient as a standalone for chronic insomnia
Caffeine and alcohol limits[17]	**Avoid alcohol during taper**; limit caffeine — both lower seizure threshold and worsen withdrawal	**Alcohol cross-tolerance can mask withdrawal severity**
Moderate aerobic exercise[43]	**~150 minutes/week** as tolerated	**Supports anxiety and sleep outcomes** — addresses the underlying indications for use
Caregiver engagement[17]	**Educate family/caregivers on BZD risks and the taper timeline**	Improves adherence, especially with early cognitive impairment
Mindfulness-based practices (adjunct)[39]	Supportive adjunct during taper for withdrawal-related symptoms — not a standalone deprescribing strategy	No compelling evidence as a standalone; modest benefit for anxiety/sleep in older adults

ABBREVIATIONS: BZD = benzodiazepine; CBT = cognitive behavioral therapy; CBT-I = cognitive behavioral therapy for insomnia; NNT = number needed to treat; VBC = value-based care; YAWNS NB = Your Answers When Needing Sleep in New Brunswick trial

Medication Safety and Key Interactions

INTERACTION/AGENT	MECHANISM/CONSEQUENCE*	CLINICAL ACTION
BZD + opioids[17]	Synergistic CNS and respiratory depression at GABA and mu-opioid receptors; **88%** of BZD-involved overdose deaths also involved opioids, and **13.7%** of opioid-involved overdose deaths also involved BZDs	**Avoid concurrent use where possible**; if co-prescribed, document necessity and informed consent, monitor respiratory status, and consider naloxone; refer for integrated OUD + SHA-UD care
BZD + alcohol	Additive CNS depression and GABA cross-tolerance; co-occurring AUD raises misuse risk **(OR 2.3)** and overdose/mortality risk[12]	**Screen for alcohol at every encounter** (AUDIT-C/CAGE); code **F10.x** separately if criteria met; counsel strict avoidance during taper
BZD + antipsychotics[44]	Additive sedation, falls, aspiration, and QTc prolongation — especially hazardous in older adults with dementia	**Minimize simultaneous use**; if necessary use the lowest doses; document rationale; fall-risk assessment
BZD in documented dementia	Worsens memory, learning, attention, and visuospatial function; dementia association **OR 1.65** (OR **2.81** for long half-life agents); triggers HEDIS DAE-Dementia[21]	**Do not initiate or continue**; begin deprescribing; document alternatives tried; code **F13.27** if cognitive deficits are sedative-induced
BZD in documented falls history (W-codes)	Fall-related hospitalization **HR 1.13** and hip fracture HR 1.3 for chronic vs. intermittent use; triggers HEDIS DAE-Falls[20]	**Do not initiate or continue**; begin deprescribing; refer for fall-risk assessment and physical therapy
BZD + gabapentinoids (gabapentin, pregabalin)[17]	Additive CNS and respiratory depression, sedation; both carry misuse and fall risk in older adults	Use as taper adjuncts only with explicit risk-benefit analysis; monitor for additive sedation; fall precautions
Long half-life BZD (e.g., diazepam) in older adults[45]	Prolonged elimination and active metabolite accumulation from age-related hepatic changes — prolonged sedation and falls; higher dementia association (**OR 2.81** for long half-life agents); however, short-acting BZDs have not been shown to carry lower fall risk than long-acting BZDs	Prefer agents without active metabolites (lorazepam, oxazepam) **during a transitional taper period only** if a BZD is unavoidable; AGS Beers Criteria recommend avoiding all BZDs — both long- and short-acting — in adults ≥65; do not interpret this preference as endorsing ongoing short-acting BZD use

INTERACTION/AGENT	MECHANISM/CONSEQUENCE*	CLINICAL ACTION
Z-drugs as a taper substitute[17]	Zolpidem, eszopiclone, zaleplon act at the same GABA-A receptor — substituting them does not resolve dependence	**Do not substitute Z-drugs for insomnia during taper**; use melatonin or trazodone (non-GABAergic)
Flumazenil[17]	Can **precipitate severe withdrawal** and panic reactions; one trial terminated early	**Not recommended** for routine use in BZD discontinuation
Adjunctive agents during withdrawal[41]	Carbamazepine, pregabalin, paroxetine, imipramine — all low-quality evidence; no single agent routinely recommended	Primary strategy is to **slow the taper**; use adjuncts case-by-case with attention to fall and misuse risk

ABBREVIATIONS: AUD = alcohol use disorder; AUDIT-C = Alcohol Use Disorders Identification Test - Consumption; BZD = benzodiazepine; CAGE = Cut down, Annoyed, Guilty, Eye-opener screen; CNS = central nervous system; DAE = Avoidance of Drug-Disease Interactions in the Elderly (HEDIS); FDA = US Food and Drug Administration; GABA = gamma-aminobutyric acid; HEDIS = Healthcare Effectiveness Data and Information Set; OR = odds ratio; OUD = opioid use disorder; PK = pharmacokinetic; QTc = corrected QT interval; SHA-UD = sedative, hypnotic, or anxiolytic use disorder
***Consult FDA labels for the most up-to- date dosage information, contraindications, and drug-drug interactions**

When to Refer

CRITERION	SPECIALIST/SETTING	URGENCY
Withdrawal seizure or delirium[17]	Emergency department; inpatient withdrawal management	**Emergent**
Suspected overdose (especially with opioids/alcohol)[17]	Emergency department; consider naloxone	**Emergent**
Acute suicidality during intoxication or withdrawal[17]	Emergency psychiatric evaluation; 988 Lifeline	**Emergent**
Withdrawal with perceptual disturbance (F13.232)[1]	Addiction medicine/psychiatry; possible inpatient	**Urgent** (same/next day)
Autonomic instability during taper (HR >100, diaphoresis, hypertension)[1]	Urgent medical evaluation; pause taper	**Urgent** (same/next day)
History of prior withdrawal seizures while tapering[17]	Addiction medicine/psychiatry	**Urgent** (within days)
Failed ≥2 outpatient taper attempts[17]	Addiction medicine/psychiatry for structured withdrawal management	Expedited (within days)
Severe co-occurring psychiatric disorder complicating taper[17]	Psychiatry	Expedited (within days)

CRITERION	SPECIALIST/SETTING	URGENCY
Concurrent opioid use disorder[17]	Addiction medicine for integrated treatment	Expedited (within days)
New cognitive decline during/after BZD use[21]	Geriatrics/neuropsychology for assessment	Routine (within weeks)
Suspected diversion or transgressional behavior[17]	Formal SUD assessment	Routine (within weeks)
Stable low-risk taper in primary care[2]	Managed within primary care with CBT support	Routine

ABBREVIATIONS: BZD = benzodiazepine; CBT = cognitive behavioral therapy; HR = heart rate; SUD = substance use disorder

Follow-Up Timing

PARAMETER/STAGE	FREQUENCY	THRESHOLD/MONITORING
New SHA-UD diagnosis (HEDIS IET)[36]	Follow-up or treatment service within **14 days**; two more within 34 days	Schedule at the **point of diagnosis** to meet Initiation and Engagement numerators
BZD dose (diazepam equivalents)[17]	**Every visit** during taper	**No reduction in 4+ weeks → reassess pace**; any dose increase → reassess the plan
Withdrawal symptom checklist[42]	**1-2 weeks** after each dose reduction	**Mild/transient (≤2 weeks)** → continue; **persistent (>2 weeks)** → pause/slow; **autonomic instability → urgent evaluation**
Vital signs (HR, BP, RR)[17]	**Every visit during active taper;** 1-**2 weeks** post-reduction	**HR >100** or disproportionate BP elevation → pause taper; assess for delirium if altered mental status
Insomnia Severity Index (ISI)[18]	Baseline; **q2-4** weeks during taper; post-taper[18]	**≥15 = moderate** → intensify CBT-I; **≥8-point drop** = improvement; **<8 = remission**[18]
GAD-7 (anxiety)[46]	Baseline; **q2-4** weeks during taper	≥10 = moderate → assess treatment-emergent vs. withdrawal anxiety; intensify CBT or add non-BZD anxiolytic
Cognitive screen (MoCA/MMSE)[47]	Baseline; **3 months; 6 months**	**MoCA <26 = impairment** → assess sedative-induced (F13.27) vs. neurodegenerative disease

PARAMETER/STAGE	FREQUENCY	THRESHOLD/MONITORING
Timed Up and Go (fall risk)[48]	Baseline; **quarterly during taper**	**>12 seconds = increased fall risk** → fall-prevention referral; home safety assessment
PDMP review[34]	**Every visit** (minimum q90 days)	Multiple prescribers → address with patient; possible diversion → formal SUD assessment
Urine drug screen[17]	**At taper initiation**; periodically by clinical judgment	Unexpected substances → revise plan; absent expected BZD → possible diversion/non-use

ABBREVIATIONS: BP = blood pressure; BZD = benzodiazepine; CBT = cognitive behavioral therapy; CBT-I = cognitive behavioral therapy for insomnia; GAD-7 = Generalized Anxiety Disorder 7-item scale; HR = heart rate; IET = Initiation and Engagement of SUD Treatment (HEDIS); ISI = Insomnia Severity Index; MMSE = Mini-Mental State Examination; MoCA = Montreal Cognitive Assessment; PDMP = Prescription Drug Monitoring Program; RR = respiratory rate; SUD = substance use disorder

Comorbidity Management — Primary Care Role

COMORBIDITY	APPROACH	CAUTION
Falls/fracture risk	**Fall-risk assessment**; Timed Up and Go; physical therapy; the taper itself reduces risk	Chronic BZD use raises falls **(HR 1.13)** and hip fracture **(HR 1.34)** independent of dose[20]
Cognitive impairment/dementia	Cognitive screening; **deprescribe BZD**; engage caregiver in medication management	**BZD worsens cognition**; long half-life agents carry higher dementia association **(OR 2.81)**; HEDIS DAE-Dementia[21]
Co-occurring anxiety[17]	**Treat with CBT and non-BZD anxiolytics**; distinguish primary from substance-induced (F13.280/F13.24)	**Inter-dose withdrawal can mimic worsening anxiety and drive escalation**
Co-occurring insomnia[35]	**CBT-I first-line**; melatonin or trazodone if pharmacologic support needed	**Do not substitute Z-drugs** — same receptor action perpetuates dependence
Depression[17]	PHQ-9; optimize antidepressant before/during taper	**Chronic BZD use can worsen depressive symptoms**; distinguish from substance-induced mood disorder
Opioid co-use[17]	**Coordinate integrated care**; continue established OUD medications	Combined respiratory depression and overdose risk; FDA Boxed Warning; **do not stop buprenorphine/ methadone for the BZD taper**

COMORBIDITY	APPROACH	CAUTION
Alcohol use disorder[49]	**Screen (AUDIT-C)**; coordinate AUD treatment; code F10.x separately	GABA cross-tolerance complicates withdrawal; alcohol lowers seizure threshold
Chronic pain[17]	Address with **non-sedative analgesia and non-pharmacologic strategies**	Older adults often use BZDs as self-treatment for pain; **frame the taper as helping, not punishing**
Polypharmacy[39]	**Medication reconciliation at every visit**; pharmacist review; deprescribing	Compounded sedation and interaction risk; pharmacist-led review adds the largest deprescribing effect

ABBREVIATIONS: AUD = alcohol use disorder; AUDIT-C = Alcohol Use Disorders Identification Test - Consumption; BZD = benzodiazepine; CBT = cognitive behavioral therapy; CBT-I = cognitive behavioral therapy for insomnia; DAE = Avoidance of Drug-Disease Interactions in the Elderly (HEDIS); FDA = US Food and Drug Administration; GABA = gamma-aminobutyric acid; HEDIS = Healthcare Effectiveness Data and Information Set; HR = hazard ratio; OR = odds ratio; OUD = opioid use disorder; PHQ-9 = Patient Health Questionnaire-9 ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Cost-Smart Options

There are **no FDA-approved pharmacotherapies specific to SHA-UD**. The cost-smart options are generic versions of the SHA drugs used in the supervised taper, plus FDA-cleared behavioral treatment.

BRAND	COST-SMART ALTERNATIVE	EST. SAVINGS	TIP
Z-DRUGS — supervised taper			
Lunesta (eszopiclone) ~$637[50]	Generic eszopiclone **~$5.00**[51]	~$632 **(~99%)**	Always use generic during taper; deprescribe rather than continue indefinitely
Ambien CR (zolpidem ER) ~$500–600[52]	Generic zolpidem ER **~$15–20**[53]	~$480–580 **(~95%)**	Always use generic; extended-release preferred over IR for taper manageability
BZDs — supervised taper			

BRAND	COST-SMART ALTERNATIVE	EST. SAVINGS	TIP
Ativan (lorazepam) ~$200–400[54]	Generic lorazepam **~$10.51**[55]	~$190–390 **(~95%)**	Short-to-intermediate half-life; suitable for most outpatient tapers at standard doses
Klonopin (clonazepam) ~$111[56]	Generic clonazepam **~$4.80**[57]	~$106 **(~96%)**	Longer half-life than lorazepam; smoother taper profile for some patients
Valium (diazepam) ~$473[58]	Generic diazepam **~$11.86**[59]	~$461 **(~97%)**	Longest half-life; used for cross-taper in complex or high-dose cases per ASAM/ACMT CPG
BEHAVIORAL TREATMENT — concurrent with taper[60]			
In-person CBT-I ~$100–300+/session × 4–8 sessions	Somryst (FDA-cleared Rx digital CBT-I) **~$899** full 9-week course; VA Insomnia Coach: **free**		CBT-I + taper achieves **70% vs. 24%** discontinuation at 12 months (NNT 2); Somryst requires prescription

ABBREVIATIONS:ABBREVIATIONS: ACMT = American College of Medical Toxicology; ASAM = American Society of Addiction Medicine; BZD = benzodiazepine; CBT-I = cognitive behavioral therapy for insomnia; CPG = clinical practice guideline; ER = extended release; IR = immediate release; NNT = number needed to treat; VA = Veterans Affairs ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Patient Education and Adherence

Patient education for SHA-UD must **address** both the **stigma** that impairs honest self-reporting and the **safety knowledge required** for taper management. Reframing dependence as a medical condition of the brain's GABA system is clinically necessary. Patients who understand the physiological basis of their condition engage more honestly in self-monitoring, which is essential to safe taper execution. In older adults, cognitive decline may impair dose tracking, polypharmacy increases cross-tolerance risk, and caregiver involvement is often critical to taper safety.

Five areas require explicit instruction before and during the taper:

- **Why abrupt cessation is contraindicated**: Seizures, delirium, and death can occur at doses above 10 mg diazepam-equivalent daily, and this risk is what necessitates a gradual schedule
- **Expected rebound symptoms**: Mild anxiety and insomnia are expected within the first two to four weeks of dose reduction and are usually transient; patients who anticipate these symptoms are less likely to interpret them as treatment failure

- **Daily self-monitoring**: Patients should track dose taken versus prescribed, any urge to increase the dose, and sleep quality using the abbreviated ISI-3 at home
- **Substance avoidance**: Strict avoidance of alcohol and all other sedatives during the taper is required, as cross-tolerance can mask withdrawal severity
- **Warning signs requiring immediate action**: Shakiness, diaphoresis, tachycardia, unusual anxiety, or perceptual disturbances require same-day contact; seizure or loss of consciousness warrants a **911** call, and suicidal ideation warrants immediate contact with the **988 Lifeline**. Patient-directed pacing within a safe clinical window improves adherence, and caregiver involvement should be arranged when cognitive impairment is present

DOCUMENTATION — PATIENT EDUCATION

Document the topics covered (why a gradual taper, expected rebound symptoms and their timeline, self-monitoring, alcohol/sedative avoidance, warning signs and the 911/988 thresholds), the person's understanding via teach-back, and any caregiver involvement. Education documentation supports continuity, shared decision-making, and signals to other clinicians that the taper plan is person-aligned.

Quality Metrics Tie-In

MEASURE[61,62]	STANDARD	APPLICABILITY TO SHA-UD
HEDIS COB/CMS Part D Star: Concurrent Use of Opioids and Benzodiazepines	**Denominator:** Part D members ≥18 with concurrent opioid and benzodiazepine prescription fills; **Numerator:** members with overlapping opioid and BZD days supply for **≥30 cumulative days** **Exclusions:** active cancer diagnosis during the measurement year; sickle cell disease; hospice; **inverse measure — lower rate is better performance**	Any active **F13.xx** patient receiving concurrent opioid therapy appears in this denominator; concurrent use for ≥30 days triggers the numerator — BZD taper, dose reduction, or discontinuation removes the member; if co-prescribing is clinically unavoidable, follow CMS five-principle framework: avoid initiation, limit dose and duration, taper gradually, monitor closely, and co-prescribe naloxone for high-risk patients; document risk counseling and taper plan at every encounter; coordinate with all prescribers to prevent cross-prescribing

MEASURE[61,62]	STANDARD	APPLICABILITY TO SHA-UD
CMS Stars C15/HEDIS FRM: Reducing the Risk of Falling	**Denominator:** MA members ≥65 with a fall or balance/walking problem (HOS Q45–Q46 positive) and ≥1 practitioner visit in the past 12 months **Numerator:** received a fall-prevention or balance/walking recommendation from a practitioner (HOS Q47) **Exclusions:** no practitioner visit in past 12 months; hospice; weight = 1; higher is better; 5-star cut ≥71%	BZDs are a top-tier modifiable fall-risk medication; documenting BZD deprescribing counseling, a fall risk assessment (STEADI, TUG), or physical therapy referral directly satisfies HOS Q47; frame every taper conversation as fall prevention; concurrent documentation also improves HEDIS DDE–Falls
CMS Stars C20/HEDIS TRC: Transitions of Care	**Denominator:** MA members ≥18 with any inpatient discharge **Numerator:** average of 4 sub-measure rates within 30 days: (1) notification of admission, (2) receipt of discharge information, (3) patient engagement after discharge, (4) medication reconciliation post-discharge **Exclusions:** hospice; death; readmissions merged into single episode (first admit/last discharge within 31 days)	**F13.230** (uncomplicated withdrawal) and **F13.23x** hospitalizations directly trigger the TRC denominator; document BZD taper schedule and cross-tapered agents at discharge; schedule follow-up before patient leaves the facility to document the patient engagement sub-measure
HEDIS IET: Initiation and Engagement of SUD Treatment	**Denominator:** MA members ≥13 with a new SUD diagnosis (**F10–F19.xx**, including **F13.xx**) and no SUD treatment in the prior 60-day clean period **Numerator:** Rate 1 (Initiation) — ≥1 SUD treatment service within 14 days of diagnosis; Rate 2 (Engagement) — ≥2 additional SUD treatment services within 34 days of initiation **Exclusions:** hospice; death; any SUD treatment in the 60-day look-back window	A new **F13.xx** diagnosis triggers the denominator — schedule follow-up at the point of diagnosis to document the 14-day window;use SUD-specific CPT/HCPCS codes for numerator documentation

MEASURE[61,62]	STANDARD	APPLICABILITY TO SHA-UD
HEDIS DDE (formerly DAE): Drug-Disease Interactions — Dementia & Falls	**Denominator:** Rate 1 (Dementia) — MA members ≥67 with dementia **(F01–F03.xx, G30.xx, G31.09, G31.83)**; Rate 2 (Falls) — MA members ≥67 with documented fall/injury **(W00–W19.xx, Z87.39x)** **Numerator:** ≥1 BZD or non-BZD sedative-hypnotic fill during the measurement year (both rates); **Exclusions:** hospice; ESRD	Each BZD deprescription removes one member from the numerator; document dementia ICD-10 codes **(F01–F03, G30, G31)** and falls history **(W00–W19, Z87.39x)** accurately at every visit; deprescribing rationale and taper schedule should be recorded for the audit trail
Former CMS Part D Star/MIPS 238: Use of High-Risk Medications in Older Adults	**Denominator:** patients ≥67 with ≥2 outpatient encounters **Numerator:** ≥2 fills of the same high-risk drug class (including BZDs, per AGS Beers Criteria) or ≥2 high-risk medications **Exclusions:** hospice; palliative care	BZDs are among the most commonly flagged drug classes in HRM events for older adults; continued prescribing worsens MIPS 238 performance; each documented taper or discontinuation reduces the numerator; deprescribing directly improves the measure
HEDIS FUH: Follow-Up After Hospitalization for Mental Illness	**Denominator:** MA members ≥6 with inpatient discharge with principal diagnosis of mental/behavioral health condition (**F01–F99.xx,** including **F13.2xx**) **Numerator:** Rate 1 — ≥1 outpatient MH follow-up within 7 days of discharge; Rate 2 — ≥1 within 30 days **Exclusions:** hospice; death; discharge AMA; readmission within the follow-up window	**F13.230/F13.231** withdrawal hospitalizations qualify the denominator; schedule follow-up at the time of inpatient discharge — do not rely on patient self-scheduling; for co-occurring diagnoses (F13 + F32/F33, F40/F41), document both to support denominator documentation; 7-day follow-up should remain the operational target
HEDIS AUS/MIPS CMS2: Unhealthy Alcohol/Drug Use: Screening and Brief Counseling	**Denominator:** HEDIS AUS — MA members ≥18; MIPS CMS2 — patients ≥18 with ≥2 outpatient encounters **Numerator:** Rate 1 — documented screening; Rate 2 — brief counseling or referral for positive screens **Exclusions:** hospice; palliative care; patient refusal	Ask directly about BZD use, sleep medications, and alcohol co-use within the SBIRT workflow; document screening tool (AUDIT-C, CAGE, DAST-10), result, and response; brief counseling ≥5 min with motivational interviewing satisfies the brief intervention component; billable under CPT 99408/99409

MEASURE[61,62]	STANDARD	APPLICABILITY TO SHA-UD

ABBREVIATIONS: AMA = against medical advice; AUS = Unhealthy Alcohol Use Screening and Follow-Up; BZD = benzodiazepine; CMS = Centers for Medicare & Medicaid Services; COB = Concurrent Use of Opioids and Benzodiazepines; DAE = Avoidance of Drug-Disease Interactions in the Elderly (former HEDIS label); DDE = Potentially Harmful Drug-Disease Interactions in the Elderly; ESRD = end-stage renal disease; FRM = Fall Risk Management; FUH = Follow-Up After Hospitalization for Mental Illness; HEDIS = Healthcare Effectiveness Data and Information Set; HOS = Health Outcomes Survey; HRM = Use of High-Risk Medications in Older Adults; IET = Initiation and Engagement of SUD Treatment; MA = Medicare Advantage; MIPS = Merit-based Incentive Payment System; MH = mental health; SBIRT = Screening, Brief Intervention, and Referral to Treatment; SHA = sedative-hypnotic-anxiolytic; STEADI = Stopping Elderly Accidents, Deaths & Injuries; SUD = substance use disorder; TRC = Transitions of Care; TUG = Timed Up and Go

QUALITY OUTCOME

When primary care screens at refill and wellness visits, stages severity by DSM-5 criteria and codes the correct **F13.2x** complication subcode, initiates an individualized supervised taper paired with CBT, schedules follow-up **within 14 days** of a new diagnosis (HEDIS IET), and deprescribes in patients with dementia or falls history (HEDIS DAE), people experience fewer falls, fractures, and cognitive harms, and the practice improves on the HRM, DAE, and IET measures simultaneously. Accurate representation of clinical complexity and dignity-first care move together.

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

ELEMENT	DOCUMENTATION REQUIREMENT
Abuse vs. dependence (severity)	**Map DSM-5 severity to ICD-10**: mild (2-3 criteria) = **F13.1x** abuse; moderate (4-5) and severe (≥6) = **F13.2x** dependence. Document the criterion count
Physiological dependence	State 'tolerance to benzodiazepine effects,' 'withdrawal symptoms upon dose reduction,' or 'meets ≥4 DSM-5 criteria' to support the **F13.2x** series
Withdrawal specificity	**F13.230** (withdrawal, uncomplicated); **F13.231** (withdrawal delirium); **F13.232** (withdrawal with perceptual disturbance) — document the specific signs
Induced disorders	Code induced anxiety **(F13.280/F13.24)**, induced sleep disorder **(F13.282/F13.182)**, induced mood disorder, and induced persisting dementia **(F13.27)** when substance-attributable

ELEMENT	DOCUMENTATION REQUIREMENT
Psychotic complications	**F13.x50** (delusions) vs. **F13.x51** (hallucinations) explicitly attributed to sedative use; document outside withdrawal delirium
Z-drug specificity	Zolpidem, eszopiclone, and zaleplon are coded in the **F13** series when use-disorder criteria are met — not **F51** or **G47.00**
Avoid no-HCC defaults	Do not default to **F13.10** (abuse, uncomplicated) or **F13.90** (unspecified, uncomplicated) when dependence features or complications are documentable
In-remission status	**F13.11/F13.21** when the person previously met criteria but has ceased use and the diagnosis remains clinically relevant
Co-occurring substance use	Code alcohol **(F10.x)** and opioid **(F11.x)** use disorders separately given cross-tolerance and combined respiratory-depression risk
Comorbidities — frequently undercoded	Code falls **(W19.x)** and fractures **(S72.x)** alongside SHA-UD; dementia **(G30.x/F03.x)**; depression **(F32.x/F33.x)**; long-term medication status **(Z79.x)**
Indication and prior taper attempts	Document the original indication and any prior tapering attempts

ABBREVIATIONS: DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; HCC = Hierarchical Condition Category; ICD-10 = International Classification of Diseases, 10th Revision; SHA-UD = sedative, hypnotic, or anxiolytic use disorder

Annual Clinical Review and Confirmation

- **Annual review:** An active SHA-UD diagnosis must be reassessed annually with MEAT documented. For a person actively tapering, in maintenance, or in monitored remission, the diagnosis remains current and requires ongoing documentation each year, including the criterion count and any complications
- **Visit modality:** A face-to-face or synchronous audio-video telehealth encounter qualifies when it supports meaningful clinical evaluation; chart updates without an encounter do not satisfy MEAT
- **Clinical context:** Under CMS-HCC V28, sedative/hypnotic/anxiolytic dependence with non-psychotic complications maps to **HCC 137** , and use with psychotic complications maps to HCC 135
- **Avoid rollover:** Do not copy forward last year's note without updating the current DSM-5 criterion count and severity, the taper status and current dose in diazepam equivalents, active complications (withdrawal, induced anxiety/sleep disorder, cognitive change), screening and monitoring results

(SDS, ISI, GAD-7, cognitive screen, fall risk), and the co-occurring substance and comorbidity burden

Good Documentation — EHR Tips

EHR TIP	WHAT TO INCLUDE
Problem-list precision	'Sedative, hypnotic, or anxiolytic dependence, moderate, with withdrawal **(F13.230)** — 4 DSM-5 criteria; on supervised taper' — not 'benzo use'
Severity and criterion-count field	A discrete field capturing the DSM-5 criterion count and resulting severity to justify **F13.1x** vs. **F13.2x**
Smart phrases/dot phrases	Macros for the two-question screen and SDS result; taper visit (current dose in diazepam equivalents, % reduction, withdrawal checklist); and induced-disorder documentation
Z-drug coding prompt	An alert that zolpidem/eszopiclone/zaleplon use disorder is coded in the **F13** series, not as insomnia
Taper-status field	A status banner: 'Assessment,' 'Active taper — week N,' 'Maintenance,' or 'Remission **(F13.21)**' at the top of every note
Monitoring flags	Recurring reminders for withdrawal reassessment 1-2 weeks after each reduction, ISI/GAD-7 q2-4 weeks, cognitive screen at 3 and 6 months, Timed Up and Go quarterly, and PDMP review
IET scheduling prompt	An automatic prompt to schedule follow-up within 14 days of a new F13 diagnosis and two more within 34 days (HEDIS IET)
Person-first language templates	Templates that default to 'a person with a sedative use disorder' and 'physiological dependence on a benzodiazepine,' **avoiding stigmatizing terms**

ABBREVIATIONS: BZD = benzodiazepine; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; GAD-7 = Generalized Anxiety Disorder 7-item scale; IET = Initiation and Engagement of SUD Treatment (HEDIS); ISI = Insomnia Severity Index; PDMP = Prescription Drug Monitoring Program; SDS = Severity of Dependence Scale

Brief Case Examples

SUCCESS — Screening at Refill, Severity-Coded, Supervised Taper with CBT-I

Patient: 74-year-old man on lorazepam 1 mg three times daily for 9 years; reduced medication effect, a prior failed cessation with withdrawal, and two near-falls; lives alone; ISI 18, GAD-7 11, Timed Up and Go 13 s.

Documentation: 'Two-question screen positive; SDS administered. DSM-5 criteria met: tolerance, withdrawal on prior cessation, unsuccessful efforts to cut down — moderate severity. Sedative, hypnotic, or anxiolytic dependence, uncomplicated, moderate **(F13.20)**. PDMP: single prescriber, consistent fills. Gradual supervised taper initiated (~20% per week) with concurrent CBT-I; reassess 1-2 weeks after each reduction.'

Outcome: Follow-up scheduled within 14 days (HEDIS IET Initiation). Over 12 weeks the dose was reduced stepwise with two planned pauses for rebound anxiety; CBT-I addressed the insomnia (ISI fell from 18 to 7). **F13.20** documented annually with the criterion count; person-first language throughout. Falls risk reassessed; no falls during the taper.

PITFALL — Unspecified Code, No Severity, Missed Dependence

Documentation as written: '68-year-old woman, anxiety, Xanax refill given. Sedative use, unspecified (F13.90). Long-term benzo, doing fine'

Consequence: F13.90 carries no HCC weight despite documented tolerance and an unsuccessful quit attempt that meet dependence criteria. No DSM-5 criterion count; no severity. The Z-drug/BZD use disorder is framed as routine anxiety management, missing the **F13.2x** dependence series and its HCC 137 documentation. The indication and prior taper attempt are not documented

RAF Impact: Moderate sedative dependence (**HCC 137**, CNA RAF **0.424**) is underdocumented because **F13.90** was assigned instead of **F13.20**. If withdrawal with perceptual disturbance **(F13.232)** or induced anxiety **(F13.280)** were present and documented, they would also map to HCC 137 — additional complexity is lost

Fix: Document explicitly: 'Sedative, hypnotic, or anxiolytic dependence, moderate **(F13.20)** — meets 4 DSM-5 criteria including tolerance and prior withdrawal. Indication: anxiety/insomnia, 7 years. Two-question screen positive. Gradual supervised taper with concurrent CBT initiated; follow-up within 14 days (HEDIS IET). Person-first language; **F13.90** is not appropriate when dependence features are documentable'

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