AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Alcoholic Dependence

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Alcohol use disorder (AUD), historically termed **alcohol dependence**, is a chronic, relapsing medical condition characterized by **impaired ability to control or stop alcohol use** despite adverse health, social, or occupational consequences.[1] It is best understood and managed as a **chronic disease** – like diabetes or hypertension – rather than a behavioral or willpower problem, with the strongest outcomes achieved when evidence-based medication and counseling are combined and patients receive scheduled follow-up. **In older adults, the diagnosis is frequently missed**: standard social and occupational impairment criteria may be irrelevant in retired or homebound patients, so harm is better assessed through falls, cognitive change, medication interactions, and functional decline.[2,3]

ICD-10 Codes:

Alcohol-related diagnoses sit in the **F10** category, organized into three mutually exclusive tiers - use **(F10.9-)**, abuse **(F10.1-)**, and dependence **(F10.2-) -** that cannot be coded together for the same encounter. Only the dependence codes carry risk-adjustment weight. **F10.20** (alcohol dependence, uncomplicated) and **F10.21** (in remission) are the base codes; complication-specific codes include **F10.230/F10.239** (with withdrawal), **F10.24** (alcohol-induced mood disorder), **F10.280** (anxiety disorder), **F10.282** (sleep disorder), and **F10.288/F10.29** (other/unspecified induced disorder). Psychotic and severe neurocognitive complications map to a separate, higher-weighted category: **F10.231** (withdrawal delirium), **F10.232** (withdrawal with perceptual disturbance), **F10.250/F10.251/F10.259** (alcohol-induced psychotic disorder), **F10.26** (persisting amnestic disorder/Korsakoff syndrome), and **F10.27** (persisting dementia). By contrast, **F10.10** (abuse, uncomplicated), **F10.90** (use, unspecified), and **Z72.89** (lifestyle problem, social history) do not map to any HCC and carry no risk-adjustment value.[4]

Prevalence and Burden: AUD affects an estimated **27.**[1] **million** US adults annually.[5] Among adults aged **65 and older the 12-month prevalence of AUD increased 65.2%** between 2001-2002 and 2012-2013, with binge drinking reported by **9.1%** of this age group.[6,7] Older adults are disproportionately burdened by alcohol-related harm relative to how much they drink, because age-related reductions in lean body mass, hepatic metabolism, and renal clearance increase vulnerability at lower consumption thresholds. When coexisting medical conditions are factored in, **53.3%** of drinkers aged 65 and older have potentially harmful levels of consumption. Approximately **one-third** of AUD in older adults is late-onset (first onset after about age 60), often triggered by grief, retirement, chronic pain, or social isolation.[7]

HCC/RAF V28 Mapping

ICD-10	HCC CATEGORY V28	CNA RAF	DOCUMENTATION
F10.20/F10.21 (Alcohol dependence, uncomplicated or in remission)	**HCC 139** Alcohol Use Disorder/Moderate/Severe/ Alcohol Use with Specified Non-Psychotic Complications	0.242	State **"alcohol dependence"** in the A&P with the DSM-5 criteria met; **"in remission"** when previously dependent and now controlled

ICD-10	HCC CATEGORY V28	CNA RAF	DOCUMENTATION
F10.230/F10.24/ F10.280/F10.282 (Dependence with non-psychotic complications (withdrawal, mood, anxiety, sleep)	**HCC 139** Alcohol Use Disorder/Moderate/Severe/ Alcohol Use with Specified Non-Psychotic Complications	0.242	**Name the specific induced complication and its link to alcohol**; same RAF as uncomplicated but supports clinical accuracy and medical necessity
F10.231/F10.250-.259/ F10.26/F10.27 (Dependence with withdrawal delirium, psychotic disorder, Korsakoff, or persisting dementia)	**HCC 136** Alcohol Use with Psychotic Complications	0.424	**Document the specific psychotic or neurocognitive complication with supporting findings**; this is a higher-complexity category than HCC 139
F10.10/F10.90/Z72.89 (Abuse, use unspecified, or social-history lifestyle note)	No HCC	N/A	**Carries no risk-adjustment value**; use only when the person **does not** meet dependence criteria

ABBREVIATIONS: HCC = Hierarchical Condition Category; RAF = Risk Adjustment Factor; CNA = Community Non-Dual Eligible, Aged; A&P = Assessment & Plan; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th edition; AUD = Alcohol Use Disorder *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

Risk-Adjusted Care Resources per Patient/Year[8,9]

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

Alcohol Use Disorder
~$2,517
HCC 139 · RAF 0.242

Alcohol Use with Psychotic Complications
~$4,411
HCC 136 · RAF 0.424

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings and Surveillance (Adult and Geriatric)

SERVICE/TOOL	WHEN	THRESHOLD AND NOTES	WHY IT MATTERS
Unhealthy alcohol use screening (USPSTF)[10,11]	All adults; annual screening reasonable (no fixed interval established)	USPSTF **Grade B**; use a validated instrument such as AUDIT-C or single-item screen	Establishes the **systematic, validated screening** that replaces passive social-history notation
AUDIT-C (preferred screen in elderly)[11,12]	Annual/at the AWV; patient-completed form	Positive at **≥3 for women, ≥4 for men**; for AUDIT-C ≥6 administer the DSM-5 symptom checklist	Patient-completed forms are more sensitive than oral questioning; useful in those >60 though less specific **(LR ~1.8-2.0)** than full AUDIT
Full AUDIT (10-item)	When a richer profile is needed	Standard hazardous-use cut-off ≥8; **use a lower cut-off of ≥5 for adults ≥65**[12]	Higher specificity for AUD **(LR 6.5)** than AUDIT-C[7]
MAST-G (Geriatric)	Older adults specifically	>5 "yes" answers indicates an alcohol problem **(sensitivity 91-93%, specificity 65-84%)**[7]	Designed for the late-onset and homebound patterns common in older adults
Medicare alcohol screening/counseling (G0442/G0443)[13]	G0442 once per 12 months; G0443 up to 4x/ year for positive screens	Part B covered, no beneficiary cost-sharing; layers onto the AWV	Provides the **billable platform** for screening and the brief-intervention follow-up

ABBREVIATIONS: AUDIT-C = Alcohol Use Disorders Identification Test-Consumption; AUDIT = Alcohol Use Disorders Identification Test; MAST-G = Michigan Alcoholism Screening Test-Geriatric; USPSTF = US Preventive Services Task Force; LR = likelihood ratio; AWV = Annual Wellness Visit; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th edition

Subtle Early Signs in Older Adults (>65)

SUBTLE SIGN (>65)	WHAT MAY BE OVERLOOKED	CLINICAL LINK
Recurrent falls or unexplained bruising[7]	**Attributed to age or deconditioning** rather than alcohol	**Falls and impairment** occur at lower consumption levels in older adults; any unexplained fall warrants alcohol screening
New or worsening cognitive change[7]	Mistaken for **primary dementia**	**Coexisting cognitive impairment can mask harmful drinking**; alcohol may be a reversible contributor
Poorly controlled hypertension or arrhythmia[14]	Treated as **isolated cardiovascular disease**	Alcohol misuse **exacerbates hypertension** and contributes to **atrial fibrillation and cardiomyopathy**
Drinking alone at home[7]	Goes undetected in **retired or socially isolated patients**	**Late-onset AUD often follows bereavement, retirement, or new functional loss**; screen at these transitions
Heightened medication side effects[7]	Dose adjustments made **without** asking about alcohol	**Alcohol interacts with sedating and hepatotoxic medications**, amplifying adverse effects

ABBREVIATIONS: AUD = Alcohol Use Disorder; >65 = older adults aged 65 and older

Geriatric Risk Factors

GERIATRIC RISK FACTOR	SIGNAL	IMPLICATION
Family history of AUD	**3- to 4-fold** increased risk; heritability **~50%**[1,2,15]	Heritable risk persists into later life; **ask about family history routinely**
Polypharmacy[7]	Sedatives, opioids, warfarin, and NSAIDs interact with alcohol	**Perform medication reconciliation** with an explicit alcohol-interaction review at **each visit**

GERIATRIC RISK FACTOR	SIGNAL	IMPLICATION
Social isolation/bereavement[7]	Common trigger for late-onset AUD	**Document social drivers** (e.g., SDOH assessment) and connect to social supports
Co-occurring mood or anxiety disorder[16]	Depression, anxiety, and PTSD frequently coexist with AUD	Screen for and treat co-occurring conditions concurrently, **not after the AUD**
Chronic pain or functional decline[7]	Pain and reduced activity raise substance-use risk in older adults	**Address pain and mobility** while screening for alcohol use

ABBREVIATIONS: AUD = Alcohol Use Disorder; SDOH = social determinants of health; PTSD = post-traumatic stress disorder; NSAID = nonsteroidal anti-inflammatory drug

Diagnostic Thresholds (DSM-5, AUDIT, CIWA-Ar)

CRITERION/SYSTEM	THRESHOLD	USE IN PRACTICE
DSM-5 criteria	**≥2 of 11** criteria within 12 months establishes AUD[2,17]	The **11 criteria** assess impaired control, craving, tolerance, withdrawal, role failure, and continued use despite harm
DSM-5 severity grading	**Mild = 2-3**; **moderate = 4-5; severe = ≥6** criteria[12]	**Moderate-to-severe AUD** is the clinical level that warrants **pharmacotherapy and structured follow-up**
AUDIT-C/full AUDIT	AUDIT-C ≥3 women, ≥4 men; full AUDIT ≥8 (≥5 if ≥65)[11,12]	**Screening tools flag risk**; a positive screen prompts the DSM-5 symptom checklist for diagnosis
CIWA-Ar (withdrawal severity, not diagnosis)	<10 mild; 10-18 moderate; **≥19 severe**; >8 may warrant medication[18]	**Monitors withdrawal severity**; not validated as a diagnostic instrument

ABBREVIATIONS: DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th edition; AUDIT-C = Alcohol Use Disorders Identification Test-Consumption; AUDIT = Alcohol Use Disorders Identification Test; CIWA-Ar = Clinical Institute Withdrawal Assessment for Alcohol-Revised; AUD = Alcohol Use Disorder

DSM-5 Alcohol Use Disorder Criteria Checklist

CRITERION (PAST 12 MONTHS)	POINTS
Drank more or longer than intended	**1**
Wanted to cut down or stop but couldn't	**1**
Spent a lot of time obtaining, using, or recovering from alcohol	**1**
Experienced craving	**1**
Failed to fulfill major role obligations (work, home, school)	**1**
Continued use despite relationship problems	**1**
Gave up or reduced important activities to drink	**1**
Recurrent use in hazardous situations (e.g., driving)	**1**
Continued use despite physical or psychological problems	**1**
Tolerance (needing more for the same effect)	**1**
Withdrawal symptoms, or drinking to avoid them	**1**

Severity: Mild = 2-3 criteria; **Moderate = 4-5 criteria**; **Severe = ≥6 criteria**. Moderate-to-severe AUD warrants pharmacotherapy and structured follow-up

AUDIT-C/Full AUDIT Scoring

QUESTION	RESPONSE OPTION AND POINTS (0-4 EACH)	INCLUDED IN
1. How often did you have a drink in the past year?	Never (0)/Monthly or less (1)/2-4x/ month (2)/2-3x/week (3)/ ≥4x/week (4)	AUDIT-C + full AUDIT
2. How many drinks on a typical drinking day?	1-2 (0)/3-4 (1)/5-6 (2)/7-9 (3)/≥10 (4)	AUDIT-C + full AUDIT

QUESTION	RESPONSE OPTION AND POINTS (0-4 EACH)	INCLUDED IN
3. How often ≥6 drinks on one occasion?	Never (0)/Less than monthly (1)/ Monthly (2)/Weekly (3)/Daily or almost daily (4)	AUDIT-C + full AUDIT
4. Unable to stop once started?	Same 0-4 frequency scale	Full AUDIT only
5. Failed to do what was normally expected due to drinking?	Same 0-4 frequency scale	Full AUDIT only
6. Needed a morning drink after heavy drinking?	Same 0-4 frequency scale	Full AUDIT only
7. Felt guilt or remorse after drinking?	Same 0-4 frequency scale	Full AUDIT only
8. Unable to remember the night before?	Same 0-4 frequency scale	Full AUDIT only
9. Injured yourself or someone else due to drinking?	No (0)/Yes, but not in the last year (2)/Yes, in the last year (4)	Full AUDIT only
10. Relative/friend/clinician concerned or suggested cutting down?	No (0)/Yes, but not in the last year (2)/Yes, in the last year (4)	Full AUDIT only

Cutoffs: AUDIT-C (max 12): positive ≥3 (women), ≥4 (men). **Full AUDIT** (max 40): positive **≥8** (**≥5 if age ≥65**). A positive screen prompts the DSM-5 criteria checklist for formal diagnosis

Clues to Dig Deeper

CLUE	WHAT TO DO	WHY
AUDIT-C positive but vague history[11]	Administer the DSM-5 Alcohol Symptom Checklist	Confirms whether the person meets criteria for **moderate-to-severe AUD** warranting treatment
NIAAA limits exceeded for age[7]	Quantify intake against age-specific limits (**≤3** drinks/day, **≤7**/ week for ≥65)	**Older adults reach harmful levels at lower amounts than younger adults**
Recurrent falls, memory change, or treatment-resistant hypertension[7,11]	Frame the conversation around these specific concerns	Linking alcohol to a tangible problem the person already notices motivates change in older adults

CLUE	WHAT TO DO	WHY
Drinking continues despite a known related problem[2]	Document this directly as a DSM-5 criterion	**"Continued use despite harm"** is a core dependence criterion often left unrecorded

ABBREVIATIONS: AUDIT-C = Alcohol Use Disorders Identification Test-Consumption; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th edition; NIAAA = National Institute on Alcohol Abuse and Alcoholism; AUD = Alcohol Use Disorder

Common Oversights

CLINICAL OVERSIGHT	CONSEQUENCE	BETTER PRACTICE
Relying on CAGE in older adults	Risky and binge drinking missed **(CAGE sensitivity 14-39%)**[19]	**Use AUDIT-C or MAST-G** as the primary screen in this population
Screening without structured follow-up[11]	A positive screen yields no clinical benefit	**Pair every positive screen with brief intervention** and a scheduled return visit
Mistaking alcohol-induced for primary dementia or depression[7]	Reversible alcohol contribution goes untreated	Assess the **temporal relationship to drinking before** attributing to a primary disorder
Overlooking withdrawal risk before reducing intake[20]	Unanticipated withdrawal seizures or delirium	Assess **withdrawal history and CIWA-Ar risk** before counseling abrupt cessation
Not reassessing remission status[2]	Stable, abstinent patients lose an accurate clinical picture	**Reassess at least annually** and update the clinical status (active vs in remission)

ABBREVIATIONS: CAGE = Cut down, Annoyed, Guilty, Eye-opener questionnaire; AUDIT-C = Alcohol Use Disorders Identification Test-Consumption; MAST-G = Michigan Alcoholism Screening Test-Geriatric; CIWA-Ar = Clinical Institute Withdrawal Assessment for Alcohol-Revised

Key Differentials in Elderly

DIFFERENTIAL	DISTINGUISHING FEATURE	NOTE
Primary major depressive disorder[2]	**Mood symptoms** persist well beyond abstinence	Alcohol-induced mood symptoms resolve with sustained abstinence; **both may coexist**
Primary dementia (Alzheimer/ vascular)[21,22]	**Cognitive decline** unrelated to drinking pattern	Alcohol-induced persisting dementia and Korsakoff syndrome **require a clear drinking link**
Benzodiazepine or opioid use disorder[23]	**Other sedative use** drives the presentation	**Concurrent opioid** use contraindicates naltrexone - clarify before prescribing
Essential tremor/ Parkinsonism[20]	**Tremor** without autonomic or withdrawal features	**Distinguish from alcohol withdrawal tremor** by timing relative to the last drink

ABBREVIATIONS: F10.x = ICD-10 alcohol-related diagnosis codes; AUD = Alcohol Use Disorder

Comorbidity Screening

COMORBIDITY	SCREENING ACTION	MANAGEMENT NOTE*
Alcohol-associated liver disease[24]	Check LFTs; assess for cirrhosis	**Treat as a distinct diagnosis**; naltrexone contraindicated in acute hepatitis or decompensation
Falls and fractures[7]	Document fall history and gait/balance	**Address fall risk directly**; both AUD and falls warrant attention
Depression/ anxiety/ suicidality[20]	Screen with PHQ-9/GAD-7; assess suicide risk	**Treat concurrently**; distinguish alcohol-induced mood symptoms from a primary disorder
Malnutrition/ thiamine deficiency[25]	Assess nutrition; give thiamine before glucose if at risk	**Thiamine 100 mg PO daily 3-5 days** in ambulatory withdrawal

COMORBIDITY	SCREENING ACTION	MANAGEMENT NOTE*
Cognitive impairment[26]	Brief cognitive testing	**May reflect reversible alcohol effect**; reassess after abstinence

ABBREVIATIONS: LFT = liver function test; AUD = Alcohol Use Disorder; PHQ-9 = Patient Health Questionnaire-9; GAD-7 = Generalized Anxiety Disorder-7; PO = by mouth; K70 = ICD-10 alcoholic liver disease ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

⚠ RED FLAG — EMERGENCY/ACTIVATE CRISIS RESPONSE

- **Delirium tremens** — severe confusion, hallucinations, autonomic hyperactivity; occurs in **3-5%** of hospitalized withdrawal patients
- **Withdrawal seizures** — generalized tonic-clonic, typically **6-48 hours** after the last drink, in **~10%** of symptomatic individuals
- Suspected **Wernicke encephalopathy** (confusion, ataxia, ophthalmoplegia) — give parenteral **thiamine before any dextrose**
- **CIWA-Ar score ≥19** or hemodynamic instability
- Acute hepatic decompensation (jaundice, coagulopathy, encephalopathy)
- These require **benzodiazepines** and hospital-level care

⚠ RED FLAG — URGENT (24-72 HOURS)

- **CIWA-Ar score 10-18** with a history of complicated withdrawal
- Active **suicidal ideation** in the context of alcohol-induced mood disorder or intoxication
- Persistent vomiting, marked agitation, or hallucinations despite initial outpatient management
- New-onset psychotic symptoms — evaluate for alcohol-induced psychotic disorder versus primary psychiatric illness
- Worsening of a concurrent medical or psychiatric condition during withdrawal

3 MEAT DOCUMENTATION ESSENTIALS

MEAT documentation converts a recognized alcohol use disorder into a defensible, codeable chronic condition. This requires documenting the diagnosis in the assessment and plan, with the specific **DSM-5 criteria met** named explicitly, rather than recording it only in the social history.

*Case vignette: A female patient, 74, recently widowed, presents for an Annual Wellness Visit with two falls in three months and worsening blood-pressure control. Her AUDIT-C is 5; she describes a nightly glass or two of wine "to sleep." On the DSM-5 Alcohol Symptom Checklist she endorses tolerance, drinking more than intended, and continued use despite knowing it affects her balance - meeting criteria for moderate alcohol use disorder. The clinician records **F10.20** in the assessment and plan, links it to the falls and hypertension, starts naltrexone, and schedules a two-week follow-up.*

MONITOR: "Drinking pattern: nightly wine, **1-2 glasses**, exceeds age-specific limit (**NIAAA: ≤3 drinks/day, ≤7/week for adults ≥65**). Falls: **2 episodes** in the past **3 months**. Blood pressure: worsening control despite current regimen. Medication adherence: N/A, treatment-naive. Withdrawal symptoms: none reported. Psychosocial functioning: recently widowed, lives alone."

EVALUATE: "**AUDIT-C score: 5**, positive screen. **DSM-5 Alcohol Symptom Checklist**: **3 criteria met** — tolerance, drinking more than intended, continued use despite awareness of balance impairment — consistent with **moderate alcohol use disorder**. Falls and hypertension worsening are clinically linked to alcohol use given timing and pattern. LFTs and cognitive testing not yet obtained — order today."

ASSESS: "**Alcohol use disorder, moderate** (**F10.20**), newly diagnosed. Associated with recurrent falls and worsening hypertension control — both linked to active alcohol use. No withdrawal, mood, anxiety, or neurocognitive complication identified at this time."

TREAT: "Start **naltrexone**. Counseling referral placed; peer-support connection (e.g., **SMART Recovery** or **AA**) offered and discussed. Fall-risk precautions reviewed given recent falls. Blood pressure regimen to be reassessed at follow-up once alcohol use is addressed. Follow-up scheduled in **2 weeks** to reassess adherence, side effects, and drinking pattern — same chronic-disease follow-up rhythm used for diabetes."

Clinical Documentation Elements

- **Diagnosis and severity stated** in the assessment and plan, not only the social history
- **Number and nature of DSM-5 criteria met** within the past 12 months
- **Screening instrument and score** (AUDIT-C, AUDIT, or MAST-G) and date
- **Specific induced complication** when present (mood, anxiety, sleep, withdrawal, psychotic, neurocognitive)
- **Medication initiated with dose**, plus counseling or peer-support referral
- **Follow-up interval and the quality measure** being addressed (IET initiation/engagement)
- **Active versus remission status**, reassessed at least annually

Reframing Common Documentation Shortcuts

COMMON SHORTCUT	WHY IT FALLS SHORT	REFRAME IN THE RECORD
"Drinks socially/a few beers a day" in social history	Not a diagnosis; carries no HCC and is invalid for billing	"Alcohol dependence, moderate **(F10.20)**; meets 4 DSM-5 criteria" in the A&P

COMMON SHORTCUT	WHY IT FALLS SHORT	REFRAME IN THE RECORD
"Alcohol abuse"	**F10.1-** does not map to an HCC even when dependence is present	Code **F10.2-** when the person meets dependence criteria
"Alcohol dependence" (uncomplicated) with active withdrawal noted	Misses the specific complication and clinical picture	"Alcohol dependence with withdrawal **(F10.230)**" with the symptoms documented
Withdrawal delirium recorded as uncomplicated dependence	Under-represents complexity; belongs in a higher HCC	"Alcohol dependence with withdrawal delirium **(F10.231)** -> HCC 136"

ABBREVIATIONS: HCC = Hierarchical Condition Category; A&P = Assessment & Plan; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th edition; F10.x = ICD-10 alcohol-related codes

DOCUMENTATION REMINDER IS COMPREHENSIVE CODING

Good documentation is good care. Naming the diagnosis, the criteria met, and the treatment plan in the assessment and plan does three things at once: it makes the condition visible to the next clinician, it supports the medication and follow-up the person needs, and it accurately represents clinical complexity. **Use person-first language - "a patient with alcohol use disorder," not "an alcoholic."**

4 TREATMENT AND REFERRAL QUICK GUIDE

The central behavior change for primary care is "Prescribe and Connect": for moderate-to-severe AUD, offer an FDA-approved medication, connect the patient to counseling and peer support, and schedule chronic-disease follow-up. Pharmacotherapy can be initiated in primary care without specialist referral.

Therapy Escalation Criteria

ESCALATE WHEN	ACTION	RATIONALE
Moderate-to-severe AUD identified (≥4 DSM-5 criteria)[27]	Offer first-line medication + brief counseling	**Medication plus counseling** is additive and is the evidence-based standard

ESCALATE WHEN	ACTION	RATIONALE
Persistent heavy drinking on adequate first-line therapy for 4-8 weeks[28]	Switch agent or add adjunct; consider referral	**Defines pharmacotherapy non-response**
Significant psychiatric comorbidity or suicidality[3]	Refer to addiction medicine or psychiatry; treat comorbidity concurrently	**Co-occurring disorders require integrated care**
Risk of complicated withdrawal[20]	Plan medically supervised withdrawal	**Prior seizures or delirium tremens** predict severe withdrawal

ABBREVIATIONS: AUD = Alcohol Use Disorder; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th edition

Guideline-Aligned Pharmacotherapy (APA/VA-DoD)

STEP/AGENT*	DOSE AND ROLE	GERIATRIC AND SAFETY NOTES
Oral naltrexone (first-line)[23]	**50 mg daily**; reduces return to heavy drinking **(NNT 11)** and supports abstinence **(NNT 18)**[29]	Preferred first-line, including in older adults; **contraindicated with opioid use** and in acute hepatitis or fulminant liver failure
Acamprosate (first-line alternative)	**666 mg three times daily**; abstinence NNT 11[29]	Useful when naltrexone is contraindicated; **reduce to 333 mg three times daily for CrCl 30-50** and avoid if CrCl <30; check creatinine at baseline[23,30]
Injectable naltrexone	**380 mg IM every 4 weeks**; ~5 fewer drinking days/30 days[29]	For adherence concerns; **same opioid/hepatic cautions as oral naltrexone**
Topiramate [OFF-LABEL]	**200-300 mg/day titrated slowly**; reduces drinking days[31]	**Watch paresthesias, cognitive clouding, metabolic effects** - relevant in older adults
Gabapentin [OFF-LABEL]	**900-1800 mg/day**[23]	**Effective with reasonable safety**; misuse potential, dose-adjust for renal function
Disulfiram	**250 mg daily**, most effective when supervised[23]	**Aversive reaction with alcohol; avoid in advanced liver disease and frail elders**; monitor LFTs early

STEP/AGENT*	DOSE AND ROLE	GERIATRIC AND SAFETY NOTES

ABBREVIATIONS: NNT = number needed to treat; IM = intramuscular; CrCl = creatinine clearance (mL/min); LFT = liver function test; [OFF-LABEL] = not FDA-approved for AUD; AUD = Alcohol Use Disorder
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

CLINICAL PEARL: TWO DECISION POINTS: OPIOIDS AND THE LIVER

Naltrexone is the preferred first-line agent for most older adults and can be initiated while the patient is still drinking. Two practical decision points determine agent selection: **opioid use**, which contraindicates naltrexone, and **hepatic status**, where acute hepatitis or decompensated liver disease warrants **acamprosate** instead, with dose adjustment for renal function. Evidence specific to patients aged 65 and older is limited; clinicians should extrapolate cautiously and monitor patients closely.

Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	WHAT IT INVOLVES	GERIATRIC FRAMING
Brief intervention	**5-10 minute structured conversation** after a positive screen[3]	Link alcohol to falls, memory, or medication effects; reduces excessive drinking by **~40% at 6 months**[32]
Motivational interviewing[7]	Nonjudgmental, open-ended conversation eliciting the person's own reasons to change	**Not specifically validated in older adults**; multiple contacts may help more than one
Cognitive-behavioral therapy/ MET[3]	Structured psychotherapy, often via referral	**Combine with medication**; recommended by APA, VA/ DoD, and SAMHSA
Peer support (AA, SMART Recovery)	Mutual-help participation, in person or online	**AA attendance >6 months** associated with **72%** abstinence at 16 years; seek age-comfortable groups[3]
Social-connection interventions[7]	Senior center, structured activity, address isolation	**Overcoming isolation is central for older adults**; age-specific programs improve success

ABBREVIATIONS: MET = motivational enhancement therapy; APA = American Psychiatric Association; VA/DoD = Veterans Affairs/Department of Defense; SAMHSA = Substance Abuse and Mental Health Services Administration; AA = Alcoholics Anonymous

Medication Safety and Key Interactions

AGENT	STATUS	KEY INTERACTION/CAUTION
Naltrexone*	FDA-approved for AUD	**Contraindicated with any opioid** (precipitates withdrawal) and in acute hepatitis/liver failure[11]
Acamprosate	FDA-approved for AUD	**Renal clearance**; dose-reduce for CrCl 30-50, **avoid <30**; well tolerated, no addictive potential[30]
Topiramate	[OFF-LABEL]	**CNS effects compound with alcohol and other sedatives**; cognitive clouding in elders[23]
Gabapentin	[OFF-LABEL]	**Sedation with alcohol/opioids**; misuse potential; renal dose adjustment[23]
Disulfiram	FDA-approved	**Severe reaction with any alcohol** (including hidden sources); hepatotoxicity[23]
Benzodiazepines (withdrawal only)	FDA-approved for withdrawal	**Reserve for managed withdrawal**; high fall and sedation risk with alcohol in elders[20]

ABBREVIATIONS: AUD = Alcohol Use Disorder; CrCl = creatinine clearance (mL/min); CNS = central nervous system; [OFF-LABEL] = not FDA-approved for AUD
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

When to Refer

NEED	FIRST STEP (PRIMARY CARE)	REFER TO
Uncomplicated moderate-severe AUD[11]	**Start naltrexone/acamprosate + brief counseling**; schedule follow-up	No referral needed initially; manage in primary care
Pharmacotherapy non-response[11]	**Confirm adherence**; switch or add adjunct	Addiction medicine or psychiatry
Complicated or high-risk withdrawal[3]	**Assess CIWA-Ar risk**; arrange supervised setting	Inpatient/medically supervised withdrawal
Significant psychiatric comorbidity[3]	**Treat concurrently**; assess suicide risk	Psychiatry/integrated behavioral health

NEED	FIRST STEP (PRIMARY CARE)	REFER TO
Alcohol-associated liver disease[24]	**Check LFTs**; choose hepatically safe pharmacotherapy	Hepatology/ gastroenterology

ABBREVIATIONS: AUD = Alcohol Use Disorder; CIWA-Ar = Clinical Institute Withdrawal Assessment for Alcohol-Revised; LFT = liver function test

Follow-Up Timing

PHASE	INTERVAL	FOCUS
Initiation	Within **14 days** of a new diagnosis[33]	Confirm medication tolerance; satisfies HEDIS/ MIPS IET initiation
Early stabilization	Every **2-4 weeks** for the first few months[34]	Adjust medication, monitor drinking, side effects, mood; a second visit within 34 days satisfies engagement
Maintenance	Every **1-3 months** once stable[28]	Reassess severity and remission status; reinforce supports
Annual	**At least yearly** (AWV)[11]	Re-screen, update status, review medication interactions

ABBREVIATIONS: HEDIS = Healthcare Effectiveness Data and Information Set; MIPS = Merit-based Incentive Payment System; IET = Initiation and Engagement of SUD Treatment; AWV = Annual Wellness Visit; SUD = substance use disorder

Comorbidity Management - Primary Care Role

COMORBIDITY	PRIMARY-CARE ROLE	COORDINATION
Depression/anxiety[24]	Screen and treat concurrently with the AUD	**Behavioral health** if severe or refractory
Liver disease[3]	Monitor LFTs; abstinence is the cornerstone for ALD	**Hepatology**; choose acamprosate over naltrexone if needed
Falls/mobility[7]	Medication review, gait assessment, fall prevention	**Physical therapy**; document fall history
Polypharmacy[35]	Reconcile medications with explicit alcohol-interaction review	**Pharmacist support** where available

COMORBIDITY	PRIMARY-CARE ROLE	COORDINATION
Malnutrition/thiamine[36]	Nutritional assessment; thiamine supplementation	**Dietitian** for sustained deficiency

ABBREVIATIONS: AUD = Alcohol Use Disorder; LFT = liver function test; ALD = alcohol-associated liver disease

Cost-Smart Options

BRAND (EST. COST)*	GENERIC OPTION (EST. COST)*	EST. SAVINGS	COST-SMART TIP
Brand ReVia (naltrexone oral 50mg), avg retail (~$88/month)[37]	Generic **naltrexone** oral 50mg (**~$32–35/month**)[38]	~$53–56/month	Generic oral naltrexone is first-line, affordable, covered under **Medicare Part D**, and prescribable by any licensed PCP without specialist referral; monitor LFTs at baseline and periodically — **contraindicated in acute hepatitis or liver failure**; counsel patients to avoid opioids for **7–10 days** before initiating
Brand Vivitrol (naltrexone 380mg IM monthly injection) (~$1,176–1,758/month)[39,40]	**No generic injectable exists** — generic **oral naltrexone** (~$32–35/month) is the lower-cost alternative[38]	**~$1,141–1,723/month** vs. oral generic	Vivitrol's monthly dosing improves adherence and removes daily pill burden — clinically preferred for patients with poor adherence history; reserve for patients who have failed or cannot adhere to daily oral therapy; Alkermes Vivitrol2gether co-pay program available for commercially insured patients; **Medicare Part B may cover administration** — bill under J2315; no generic available until at least 2027

BRAND (EST. COST)*	GENERIC OPTION (EST. COST)*	EST. SAVINGS	COST-SMART TIP
Brand Campral (acamprosate 333mg) — discontinued; all formulations withdrawn[41]	Generic **acamprosate** 333mg — **only available option** (**avg retail ~$217–340/180 tablets**)[42]	N/A	Prescribe generic acamprosate only; verify **stock at the patient's specific pharmacy before prescribing** — do not assume availability; acamprosate is preferred over naltrexone when **liver disease is present** (renally cleared, not hepatically metabolized); contraindicated in **severe renal impairment** (CrCl <30 mL/min); if unavailable, generic oral naltrexone is the alternative first-line agent

ABBREVIATIONS: IM = intramuscular; LFT = liver function test; CrCl = creatinine clearance; AUD = alcohol use disorder; Part B/D = Medicare Parts B and D ***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Patient Education and Adherence

- **Frame around personal values**: Center messaging on what the person values — independence, memory, and physical health — rather than social or legal consequences
- **Explain physiological change**: Alcohol affects the aging body differently, so an amount once tolerated may now cause harm
- **Normalize pharmacotherapy**: Effective, covered medications can reduce cravings, much like blood-pressure medication — position this as medical treatment, not a moral judgment.
- **Highlight concrete benefits**: Cutting back can protect memory, lower fall risk, and help other medications work as intended
- **Support the decision**: Offer a decision aid and use shared decision-making to guide the conversation

DOCUMENTATION REMINDER - PATIENT EDUCATION

Document the **education provided, the decision aid offered, and the person's response** in the record. Note any brief intervention delivered (supports G0443 and the IET measure) and the agreed follow-up plan.

Quality Metrics Tie-In

MEASURE	STANDARD	APPLICABILITY TO ALCOHOLIC DEPENDANCE
Initiation and Engagement of SUD Treatment (HEDIS/MIPS #305)[43]	**Denominator:** patients ≥13 with a new SUD episode (no SUD treatment in the 60 days prior; alcohol use disorder is a qualifying SUD cohort) **Numerator — two rates reported:** **(Rate A) Initiation:** treatment initiated within 14 days of new SUD episode (inpatient admission, outpatient visit, intensive outpatient, partial hospitalization, telehealth, or medication treatment) **(Rate B) Engagement:** ≥2 additional SUD treatment services or ≥1 long-acting medication event within 34 days of initiation **Exclusions:** patients in remission; hospice; death	Diagnose at the AWV, start medication (naltrexone or acamprosate) the same day to satisfy Rate A initiation, and schedule a 2-week follow-up visit to contribute a second service toward Rate B engagement — all achievable within primary care. Document the SUD episode date explicitly; **the 14-day and 34-day clocks begin on that date**
Unhealthy Alcohol Use Screening and Brief Counseling (MIPS #431)[44]	**Denominator:** patients ≥18 with ≥2 visits or ≥1 preventive visit during the measurement period (no alcohol diagnosis required) **Numerator (three submission criteria reported separately):** (1) screened using a validated systematic screening method within the last 12 months; (2) for those who screen positive, brief counseling provided; (3) combined: screened AND received brief counseling if identified as an unhealthy alcohol user **Exceptions:** documented medical reason for not screening (e.g., limited life expectancy)	**AUDIT-C at the AWV;** bill G0442 (annual alcohol misuse screening, 15 minutes) and G0443 (brief face-to-face counseling, 15 minutes) for eligible patients who screen positive. All three submission criteria can be documented in a single AWV encounter with proper documentation of the screening result and counseling response

MEASURE	STANDARD	APPLICABILITY TO ALCOHOLIC DEPENDANCE
Functioning for Mental and/or SUD (MIPS #502)[45]	**Denominator:** patients ≥18 with a mental and/or SUD diagnosis with a qualifying encounter AND a baseline WHODAS 2.0 (12-item) or Sheehan Disability Scale (SDS) assessment completed during the denominator identification period **Numerator:** improvement or maintenance of functioning score on WHODAS 2.0 or SDS at a follow-up assessment within 12 months of the baseline index assessment **Exceptions:** documented reason for not completing follow-up assessment (e.g., death, limited life expectancy, patient refusal)	**Administer the WHODAS 2.0 or SDS at the initial AUD encounter and again at 12-month follow-up**; track functional outcomes longitudinally rather than at a single point in time. Primary care is well positioned to anchor this measure since the denominator includes standard outpatient E&M codes
Reduction in Suicidal Ideation or Behavior Symptoms (MIPS #505)[46]	**Denominator:** patients ≥18 with a mental and/or SUD diagnosis with suicidal ideation or behavior symptoms, or clinician-determined suicide risk, with an index C-SSRS assessment completed during the denominator identification period (12-month window beginning 4 months before the measurement year) **Numerator:** reduction in suicidal ideation or behavior symptoms demonstrated on C-SSRS Screen Version or Since Last Visit within 120 days after the index assessment **Exceptions:** documented medical reason for not completing follow-up C-SSRS (e.g., death, limited life expectancy)	**Relevant given co-occurring depression and elevated suicidality in AUD**. Administer the C-SSRS at the encounter where suicidal ideation is identified; document as the index assessment with date recorded. Schedule follow-up within 120 days and re-administer C-SSRS to document the outcome. Ensure safety plan is documented concurrently (see MIPS #504 for the companion safety plan measure)

ABBREVIATIONS: AUDIT-C = Alcohol Use Disorders Identification Test-Consumption; AUD = alcohol use disorder; AWV = Annual Wellness Visit; C-SSRS = Columbia-Suicide Severity Rating Scale; HEDIS = Healthcare Effectiveness Data and Information Set; IET = Initiation and Engagement of SUD Treatment; MIPS = Merit-based Incentive Payment System; SDS = Sheehan Disability Scale; SUD = substance use disorder; WHODAS = World Health Organization Disability Assessment Schedule

QUALITY OUTCOME

When a person is **screened, diagnosed, started on medication, and seen again within two weeks**, the care team has delivered **evidence-based treatment and met the IET initiation criterion at the same time**. The quality result is a by-product of doing right by the patient - **timely, coordinated, chronic-disease care** for alcohol use disorder.

AAVBC PERSPECTIVE

AAVBC encourages primary care providers to approach alcohol use disorder as a chronic, treatable medical condition requiring active diagnosis, pharmacotherapy, and longitudinal follow-up, not a willpower problem or a counseling-only referral.

For patients with moderate-to-severe AUD, AAVBC supports initiation of **FDA-approved pharmacotherapy** in the primary care setting without deferring to addiction specialists. **Naltrexone**, available as oral daily dosing or **extended-release injectable (Vivitrol®)** monthly, is first-line and reduces alcohol craving and reinforcement. **Acamprosate** is an equally appropriate first-line option for supporting abstinence, particularly in patients with renal disease where naltrexone requires additional caution.

Alongside pharmacotherapy, AAVBC encourages proactive connection to **behavioral counseling**, including Cognitive Behavioral Therapy or Motivational Enhancement Therapy, and community support programs such as AA or SMART Recovery. Monthly follow-up visits should be scheduled initially to adjust medications, support adherence, and manage comorbidities, applying the same chronic disease management framework used for diabetes or hypertension.**This helps ensure the right patients receive the right treatment and the right longitudinal support at the right time.**

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

CODE	USE WHEN	SPECIFICITY/HCC NOTE
F10.20	Alcohol dependence, uncomplicated (meets DSM-5 criteria)	HCC 139 (CNA RAF 0.242); state criteria met in the A&P
F10.21	Previously dependent, now abstinent or controlled	HCC 139; document "in remission"; cannot be coded with **F10.20**

CODE	USE WHEN	SPECIFICITY/HCC NOTE
F10.230/F10.239	Dependence with withdrawal	HCC 139; document withdrawal symptoms (tremor, agitation, sweating)
F10.24/F10.280/F10.282	Dependence with mood, anxiety, or sleep disorder	HCC 139; name the induced complication and its alcohol link
F10.231/F10.250-.259/ F10.26/F10.27	Withdrawal delirium, psychotic disorder, Korsakoff, or persisting dementia	**HCC 136 (CNA RAF 0.424)** - higher complexity; document the specific complication
F10.10/F10.90/Z72.89	Abuse, unspecified use, or social-history note	No HCC; do not use for risk adjustment

ABBREVIATIONS: HCC = Hierarchical Condition Category; RAF = Risk Adjustment Factor; CNA = Community Non-Dual Eligible, Aged; A&P = Assessment & Plan; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th edition; F10.x = ICD-10 alcohol-related codes

Annual Clinical Review and Confirmation

- Alcohol use disorder is a chronic condition that should be **reassessed** and **re-documented** at least **once each calendar year**, typically at the **Annual Wellness Visit**, so that the diagnosis, severity, and remission status remain current
- **At each annual review**, confirm the diagnosis still applies, record whether the person is in active dependence or in remission, and re-screen for any new induced complication (mood, anxiety, sleep, withdrawal, psychotic, neurocognitive) that would change the HCC
- **Re-state the DSM-5 criteria met in the assessment** and plan rather than carrying forward a prior note unexamined; a person in stable remission is documented as **F10.21**, which still represents the condition
- **Reconcile the medication list** with an explicit alcohol-interaction review and update the treatment and follow-up plan, ensuring the record reflects ongoing, coordinated care

Good Documentation - EHR Tips

EHR TIP	HOW	PAYOFF
Bring the diagnosis into the A&P	Add **F10.2-** to the active problem list, not just the social history	Makes the condition visible and codeable
Embed the DSM-5 checklist	Trigger the symptom checklist when AUDIT-C is positive	Documents criteria met and supports severity

EHR TIP	HOW	PAYOFF
Use screening smart-codes	Map G0442/G0443 to the screening and counseling workflow	Documents the IET and screening quality measures
Flag the HCC 136 split	Alert when a psychotic or neurocognitive complication is charted	Routes to the higher-complexity HCC 136 code
Schedule the follow-up at the visit	Auto-create the 2-week return when treatment starts	Supports IET initiation and engagement timing

ABBREVIATIONS: EHR = electronic health record; A&P = Assessment & Plan; AUDIT-C = Alcohol Use Disorders Identification Test-Consumption; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th edition; HCC = Hierarchical Condition Category; IET = Initiation and Engagement of SUD Treatment

Brief Case Examples

SUCCESS - Diagnosed, Treated, and Followed Up

Patient: Female patient, 74, recently widowed, presenting for an Annual Wellness Visit with two recent falls and rising blood pressure.

Documentation: AUDIT-C 5; DSM-5 checklist shows 4 criteria. Recorded as "alcohol dependence, moderate **(F10.20)**," linked to falls and hypertension, with naltrexone started and a 2-week follow-up scheduled.

Outcome: Reduced drinking at follow-up, improved blood-pressure control, no further falls; IET initiation and engagement criteria met.

RAF impact: HCC 139 documented (CNA RAF 0.242), accurately reflecting the complexity of coordinated chronic-disease care.

PITFALL - Left in the Social History

Documentation as written: Social history: "patient drinks a few glasses of wine most nights." No diagnosis in the assessment and plan.

Consequence: Alcohol use disorder remains clinically invisible; no medication, counseling, or follow-up offered; the next clinician sees no problem to address.

RAF impact: No HCC documented; the person's complexity is not represented.[23]

Fix: Bring the diagnosis into the A&P as **F10.20** with the DSM-5 criteria met, start treatment, and schedule follow-up - converting a social-history note into recognized, treatable care.

REFERENCES

1. Rehm J, Assanangkornchai S, Hendershot CS, et al. Alcohol use disorders. *Lancet.* 2025;406(10516): 2269-2281. doi:10.1016/S0140-6736(25)01496-5
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed, text revision. American Psychiatric Association Publishing; 2022.
3. Haber PS. Identification and treatment of alcohol use disorder. *N Engl J Med.* 2025;392(3):258-266. doi: 10.1056/NEJMra2306511
4. Centers for Medicare & Medicaid Services; National Center for Health Statistics. ICD-10-CM Official Guidelines for Coding and Reporting FY 2026. US Department of Health and Human Services; 2025. Accessed June 9, 2026. https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf
5. National Institute on Alcohol Abuse and Alcoholism. Alcohol use disorder (AUD) in the United States: age groups and demographic characteristics. NIAAA/NIH. Accessed July 7, 2026. https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics/alcohol-facts-and-statistics/alcohol-use-disorder-aud-united-states-age-groups-and-demographic-characteristics
6. Grant BF, Chou SP, Saha TD, et al. Prevalence of 12-month alcohol use, high-risk drinking, and DSM-IV alcohol use disorder in the United States, 2001-2002 to 2012-2013: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *JAMA Psychiatry.* 2017;74(9):911-923.
7. Lehmann SW, Fingerhood M. Substance-use disorders in later life. *N Engl J Med.* 2018;379(24): 2351-2360. doi:10.1056/NEJMra1805981
8. Centers for Medicare & Medicaid Services. 2026 final ICD-10-CM mappings (CMS-HCC V28). CMS; 2025. Accessed July 7, 2026. https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/risk-adjustors/2026-model-software
9. Centers for Medicare & Medicaid Services. CMS-HCC model relative factor tables (community, non-dual, aged). CMS; 2024. Accessed July 7, 2026. https://www.cms.gov/files/document/revised-cms-hcc-model-relative-factor-tables.pdf
10. US Preventive Services Task Force; Curry SJ, Krist AH, et al. Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: USPSTF recommendation statement. *JAMA.* 2018;320(18):1899-1909.
11. Krist AH, Bradley KA. Addressing alcohol use. *N Engl J Med.* 2025;392(17):1721-1731. doi:10.1056/NEJMcp2402121
12. Wood E, Pan J, Cui Z, et al. Does this patient have alcohol use disorder? The rational clinical examination systematic review. *JAMA.* 2024;331(14):1212-1225.
13. Friedmann PD. Clinical practice: alcohol use in adults. *N Engl J Med.* 2013;368(4):365-373.
14. Piano MR, Marcus GM, Aycock DM, et al. Alcohol use and cardiovascular disease: a scientific statement from the American Heart Association. *Circulation.* 2025.
15. Carvalho AF, Heilig M, Perez A, Probst C, Rehm J. Alcohol use disorders. *Lancet.* 2019;394(10200): 781-792.

16. American Psychiatric Association. Practice guideline for the pharmacological treatment of patients with alcohol use disorder. American Psychiatric Association Publishing; 2018.

17. Minozzi S, La Rosa GRM, Salis F, et al. Combined pharmacological and psychosocial interventions for alcohol use disorder. *Cochrane Database Syst Rev.* 2025.

18. Tiglao SM, Meisenheimer ES, Oh RC. Alcohol withdrawal syndrome: outpatient management. *Am Fam Physician.*2021;104(3):253-262.

19. Moyer VA; US Preventive Services Task Force. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: USPSTF recommendation statement. *Ann Intern Med.* 2013;159(3):210-218.

20. American Society of Addiction Medicine. Clinical practice guideline on alcohol withdrawal management. ASAM; 2020.

21. Ridley NJ, Draper B, Withall A. Alcohol-related dementia: an update of the evidence. *Alzheimers Res Ther.*2013;5(1):.

22. Maillard A, Laniepce A, Cabé N, et al. Temporal cognitive and brain changes in Korsakoff syndrome. *Neurology.*2021;96(15):e1987-e1998.

23. Reus VI, Fochtmann LJ, Bukstein O, et al. The American Psychiatric Association practice guideline for the pharmacological treatment of patients with alcohol use disorder. *Am J Psychiatry.* 2018;175(1): 86-90.

24. Singal AK, Mathurin P. Diagnosis and treatment of alcohol-associated liver disease: a review. *JAMA.* 2021;326(2):165-176.

25. Mauermann ML, Staff NP. Peripheral neuropathy: a review. *JAMA.* 2026.

26. Ros-Cucurull E, Palma-Álvarez RF, Cardona-Rubira C, et al. Alcohol use disorder and cognitive impairment in old age patients: a 6 months follow-up study. *Psychiatry Res.* 2018;261:361-366.

27. Johnson B; National Institute on Alcohol Abuse and Alcoholism. Medication for the treatment of alcohol use disorder: a brief guide. National Institute on Alcohol Abuse and Alcoholism; 2015. Accessed July 7, 2026. https://www.niaaa.nih.gov/publications/medication-treatment-alcohol-use-disorder-brief-guide

28. Kranzler HR, Soyka M. Diagnosis and pharmacotherapy of alcohol use disorder: a review. *JAMA.* 2018;320(8):815-824.

29. McPheeters M, O'Connor EA, Riley S, et al. Pharmacotherapy for alcohol use disorder: a systematic review and meta-analysis. *JAMA.* 2023;330(18):1769-1781.

30. Acamprosate calcium delayed-release tablets [prescribing information]. Mylan Pharmaceuticals Inc; 2024. Accessed July 7, 2026. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=75ddfd10-55b2-426e-bc74-3413cd0d7c94

31. Perry C, Liberto J, Milliken C, et al. The management of substance use disorders: synopsis of the 2021 U.S. Department of Veterans Affairs and U.S. Department of Defense clinical practice guideline. *Ann Intern Med.*2022;175(5):720-731. doi:10.7326/M21-4011

32. Kelly S, Olanrewaju O, Cowan A, et al. Interventions to prevent and reduce excessive alcohol consumption in older people: a systematic review and meta-analysis. *Age Ageing.* 2018;47(2): 175-184. doi:10.1093/ageing/afx132

33. Lee AK, Bobb JF, Richards JE, et al. Integrating alcohol-related prevention and treatment into primary care: a cluster randomized implementation trial. *JAMA Intern Med.* 2023;183(4):319-328. doi:10.1001/jamainternmed.2022.7083

34. Department of Veterans Affairs/Department of Defense. VA/DoD clinical practice guideline for the management of substance use disorders. Version 4.0. VA/DoD; 2021. Accessed July 7, 2026. https://www.healthquality.va.gov/guidelines/MH/sud/

35. Harasani K, Duque S, Piotrowicz K, et al. [Title not available in PubMed]. *Aging Clin Exp Res.* 2026.

36. Díaz LA, König D, Weber S, et al. Management of alcohol use disorder: a gastroenterology and hepatology-focused perspective. *Lancet Gastroenterol Hepatol.* 2025;10(5):475-490. doi:10.1016/S2468-1253(24)00380-7

37. Revia 2026 prices, coupons & savings tips. GoodRx. Accessed July 7, 2026. https://www.goodrx.com/revia

38. Naltrexone 2026 prices, coupons & savings tips. GoodRx. Accessed July 7, 2026. https://www.goodrx.com/naltrexone

39. Vivitrol prices, coupons, copay cards & patient assistance. Drugs.com. Accessed July 7, 2026. https://www.drugs.com/price-guide/vivitrol

40. How much does naltrexone cost with and without insurance? Ophelia. Accessed July 7, 2026. https://ophelia.com/blog/how-much-does-naltrexone-cost

41. Generic Campral availability & release date. Drugs.com. Accessed July 7, 2026. https://www.drugs.com/availability/generic-campral.html

42. Acamprosate 2026 availability, prices, and tips to find. Medfinder. Accessed July 7, 2026. https://www.medfinder.com/medication/acamprosate

43. Centers for Medicare & Medicaid Services. Quality ID #305: initiation and engagement of substance use disorder treatment. 2026 MIPS CQM Specifications. Quality Payment Program. CMS. Accessed July 7, 2026. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2026_Measure_305_MIPSCQM.pdf

44. Centers for Medicare & Medicaid Services. Quality ID #431: preventive care and screening — unhealthy alcohol use: screening and brief counseling. 2026 MIPS CQM Specifications. Quality Payment Program. CMS. Accessed July 7, 2026. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2026_Measure_431_MIPSCQM.pdf

45. Centers for Medicare & Medicaid Services. Quality ID #502: improvement or maintenance of functioning for individuals with a mental and/or substance use disorder. 2026 MIPS CQM Specifications. Quality Payment Program. CMS. Accessed July 7, 2026. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2026_Measure_502_MIPSCQM.pdf

46. Centers for Medicare & Medicaid Services. Quality ID #505: reduction in suicidal ideation or behavior symptoms. 2026 MIPS CQM Specifications. Quality Payment Program. CMS. Accessed July 7, 2026. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2026_Measure_505_MIPSCQM.pdf

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