Substance use disorders

Clinical overview

Definition

American Psychiatric Association:

- Substance use disorders: A cluster of cognitive, behavioral and physiological symptoms indicating the individual continues using the substance despite significant substance-related problems.[1]

The most common drug classifications associated with substance use disorders are: [2]

- Alcohol
- Cannabis (marijuana)
- Prescription medicines (e.g., pain pills, stimulants, or anxiety pills)
- Methamphetamine
- Cocaine
- Opiates
- Hallucinogens
- Inhalants

Causes/Risk factors[3]

The exact cause of substance use disorder is not known. The main factors are:

- Environment
- Genetics

Substance use disorders and mental health problems[4]

Mental health problems and substance use disorders sometimes coexist for the following reasons:

- Mental health problems and substance use disorders share some underlying causes.
- Some people with mental health problems may turn to substance use to self-medicate.
- Use of certain substances can cause people with addiction to experience mental health issues.

Signs and symptoms[5]

Signs and symptoms are variable, depending on the particular substance being used. Examples include:

- Intoxication – feeling sleepy, calm, excited, intense emotions, impaired judgment and decision-making, or physical and mental functioning
- Withdrawal – nausea and vomiting, diarrhea, sweating, difficulty sleeping, muscle cramping and mood changes

Diagnostic tools[6]

The main diagnostic tool is:

- A thorough evaluation by a psychiatrist, psychologist, or licensed alcohol and drug counselor

Treatment[5]

- Withdrawal management (detoxification)
- Therapy (inpatient, outpatient, behavioral, family, individual, group, etc.)
- Medication(s)
    - Alcohol use disorder – acamprosate, disulfiram, and naltrexone
    - Opioid use disorder – buprenorphine, methadone, and naltrexone
    - Naloxone and nalmefene are both FDA-approved opioid overdose reversal medications

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Best documentation practices for healthcare providers

Subjective[7]

- The HPI sets the background for the patient's presenting problem, from when first diagnosed until this encounter.
- May include Review of Systems (ROS), Past, Family, and/or Social History (PFSH), Active Problems List.
- Document the presence or absence of any current or past substance use (type, amount, frequency).

Objective[7]

Document any objective data, including withdrawal symptoms, response to treatment (including both progress and challenges), and treatment refusals or non-compliance.

Assessment/Impression

Specificity: Describe each final diagnosis clearly, concisely and to the highest level of specificity. Use all applicable descriptors and include the following:

- Severity – mild, moderate, severe
- Remission – early or sustained
- Specific substance involved – use, abuse, or dependence
- Underlying cause – use linking terms such as "due to"
- All related symptoms/conditions, such as with intoxication, delirium, perceptual disturbance, withdrawal, psychotic disorder (with delusions, hallucinations, substance-induced psychotic disorder), sexual dysfunction, sleep disorder, etc. with clear cause-and-effect linkage

Plan[7]

Document a clear and concise treatment plan for substance use disorder, for example:

- Document details of referrals and consultation requests, orders for evaluation, and medications prescribed with clear linkage to the diagnosis
- Address any additional steps being taken to treat the patient

ICD-10-CM coding tips

- Substance use disorders in early or sustained remission are classified to the appropriate codes for substance abuse in remission.[8]

Use, abuse and dependence hierarchy:

When the provider documentation refers to use, abuse and dependence of the same substance (e.g., alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy: [8]

- If both use and abuse are documented, assign only the code for abuse.
- If both abuse and dependence are documented, assign only the code for dependence.
- If use, abuse and dependence are all documented, assign only the code for dependence.
- If both use and dependence are documented, assign only the code for dependence.

Substance-induced disorders

Do not assume a causal relationship between substance abuse and/or dependence (including alcohol abuse and/or dependence) and anxiety, mood disorder, sleep disorder or sexual dysfunction.[8] Although these conditions appear under "with" in the alphabetic index, the respective code descriptions in tabular list indicate these codes are reported when these conditions are described as substance-induced or alcohol-induced disorders and such a relationship is documented by the provider.[10]

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Documentation of the vaping of marijuana
Documentation of vaping use of marijuana without an associated substance related disorder or medical condition, is not a reportable diagnosis. When reporting vaping of marijuana use, abuse or dependence, follow the Official Coding Guidelines, Section I.C.5.b.3) which states, "As with all other unspecified diagnoses, the codes for unspecified psychoactive substance use (F10.9-, F11.9-, F12.9-, F13.9-, F14.9-, F15.9-, F16.9-, F18.9-, F19.9-) should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). These codes are to be used only when the psychoactive substance use is associated with a substance related disorder (chapter 5 disorders such as sexual dysfunction, sleep disorder, or a mental or behavioral disorder) or medical condition, and such a relationship is documented by the provider."[11]

Coding examples

Example 1	
Medical record documentation	Pleasant 60-year-old female here for routine follow-up for hypertension. Reports she has been feeling well and has no specific complaints today. Leaving in two weeks for vacation in Montana. Patient denies recurrence of lightheadedness/dizziness and states that, per my instructions at her last visit, she is no longer taking her opioid pain medication more often than prescribed by her pain management specialist for chronic low back pain. She has been on long-term prescribed opioid continuously for past six months. Blood pressure today is 118/82. Assessment: 1. Hypertension, stable. Continue same medication. 2. Low back pain, stable. 3. Long term opioid use – doing better since decreasing pain medication intake. Previous complaint of lightheadedness has resolved.
ICD-10-CM codes	**I1Ø** Essential (primary) hypertension **M54.5Ø** Low back pain, unspecified **Z79.891** Long-term (current) use of opiate analgesic
Rationale	• Code **F11.9Ø** Opioid use, unspecified, uncomplicated is not assigned for prescribed opioid use as described in this record. • Per the ICD-10-CM Official Guidelines for Coding and Reporting (Section I.C.5.b.3), code **F11.9Ø** should be used only when the opioid use is associated with an opioid-related disorder (chapter 5 disorders such as sexual dysfunction, sleep disorder or a mental or behavioral disorder) or medical condition, and such a relationship is documented by the provider.[8,12] • Long-term opioid use is reported with code **Z79.891**.

Example 2	
Medical record documentation	67-year-old male brought to the emergency department by his colleague. They had attended a holiday party, and the patient consumed a large amount of alcohol. Now he is difficult to arouse. Exam reveals patient in semiconscious state with cold, clammy skin; respirations slow at 8-10 per minute. Blood alcohol level 22mg/100 ml. Admitted to 12 East. Assessment: Acute alcohol intoxication
ICD-10-CM codes	**F1Ø.129** Alcohol abuse with intoxication, unspecified[13, 14] **Y9Ø.1** Blood alcohol level of 20-39 mg/100 ml

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Rationale	Category **F1Ø**, Alcohol-related disorders, advises to "Use additional code for blood alcohol level, if applicable (**Y9Ø.-**)."[13]

Example 3	
Medical record documentation	72-year-old male presents with complaints of irritability, nervousness and insomnia. States he has lost his appetite and has lost 5 pounds in the last two weeks. Admits he has been a regular marijuana smoker since age 16. His wife has been upset about his marijuana use, so he stopped cold turkey about 2-½ weeks ago. Assessment: Marijuana use withdrawal
ICD-10-CM code	**F12.93** Cannabis use, unspecified with withdrawal
Rationale	Code **F12.93** is used to report cases of physiological withdrawal from cannabis occurring in a person who is using cannabis regularly in contexts that are not defined as cannabis dependence.

Example 4	
Medical record documentation	68-year-old male presents to primary care physician's office for follow-up regarding alcoholic gastritis. He is attending AA meetings and seeing his psychiatrist for his alcohol dependence. Reports his symptoms of burning pain in the upper abdomen have subsided somewhat since he is now consistently taking omeprazole 20 mg daily as prescribed. He has also cut back on his alcohol consumption – reports drinking only on Saturdays and Sundays, – 2 beers each day. Social History states "History of cocaine dependence but has not used in 5 years." Assessment: Alcoholic gastritis, improved. Continue omeprazole 20 mg one capsule daily before breakfast. Alcohol dependence History of cocaine dependence
ICD-10-CM codes	**K29.2Ø** Alcoholic gastritis without bleeding **F1Ø.2Ø** Alcohol dependence, uncomplicated **F14.21** Cocaine dependence, in remission
Rationale	Code K29.2Ø has an instructional note advising to "Use additional code to identify alcohol abuse and dependence (**F1Ø.-**)."[13] Following the path in the ICD-10-CM manual, "Alcohol dependence" with no further specification codes to **F1Ø.2Ø** and cocaine dependence in remission codes to **F14.21**.[13]

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