

Substance use disorders

ICD-10-CM

Clinical overview

Definitions and overview

American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5):

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

World Health Organization:

- **Substance abuse:** The harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.
- **Substance dependence:** A cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance and sometimes a physical withdrawal state.

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

- Alcohol
- Depressants
- Hallucinogens
- Opioids
- Cannabis (marijuana)
- Stimulants
- Sedatives, hypnotics and anxiolytics

Diagnostic criteria

The DSM-5 manual advises the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance (such as using the substance for longer than intended; or a persistent desire to cut down or regulate the substance use; or multiple unsuccessful attempts to decrease or discontinue use).

In total, the DSM-5 outlines 11 specific criteria for diagnosing a substance use disorder and allows clinicians to specify the severity of the disorder as follows:

- Mild: 2-3 criteria met
- Moderate: 4-5 criteria met
- Severe: 6 or more criteria met

The DSM-5 also provides course specifiers and descriptive features specifiers for early remission; sustained remission; on maintenance therapy; or in a controlled environment.

NOTE: The purpose of this guideline is to address medical record documentation and diagnosis coding. In-depth diagnostic criteria are outside the scope of this document. Healthcare providers must consult the DSM-5 manual - which is the gold standard - for detailed information related to diagnostic criteria for substance use disorders.

Causes

The exact cause of substance use disorder is not known.

Some of the contributing factors include:

- Anxiety, depression or other mental health disorders (see next section)
- Genetic predisposition
- Peer pressure
- Emotional distress
- Family history of substance use disorders
- Environmental stressors
- Trauma

Substance use disorders and mental health problems

Mental health problems and substance use disorders sometimes co-exist 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

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

- Slurred speech
- Alcohol odor on breath
- Enlarged, tender liver
- Nasal irritation
- Needle marks
- Mild tremor
- Marijuana odor on clothing
- Dilated or small "pinpoint" pupils

Diagnostic tools

The main diagnostic tools are:

- Medical history and physical exam
- Blood, urine and other laboratory and diagnostic testing
- Psychological/psychiatric evaluation

Treatment

- Individual, family and group counseling
- Support groups and 12-step programs (Alcoholics Anonymous, Narcotics Anonymous, etc.)
- Inpatient and outpatient rehabilitation programs
- Treatment of underlying medical conditions
- Medications

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Best documentation practices for physicians

Subjective

- The subjective section of the office note should document current symptoms, complaints or other patient-reported information related to substance use disorder.

Objective

- In the objective section, include current associated physical exam findings (e.g., dilated pupils, nasal irritation, etc.) and diagnostic testing results.

Assessment

Specificity:

Avoid vague diagnosis descriptions, e.g., “other” or “unspecified.” Document each condition to the highest level of specificity, including the following as appropriate:

- Remission – partial or full, early or sustained
- Specific substance involved and whether there is **use** versus **abuse** versus **dependence**
- All related symptoms/conditions, such as with intoxication, psychotic behavior, sleep disturbance, withdrawal, etc.

ALERT: ICD-10-CM presumes linkage of some of these conditions; thus, it is important to be aware of those conditions and specifically indicate when they are not linked.

Abbreviations:

A good rule of thumb for any medical record is to limit - or avoid altogether - the use of abbreviations. The meaning of an abbreviation or acronym can often be determined based on context, but this is not always true. Example:

- ARCD – age-related cognitive decline versus alcohol-related cognitive disorder

Best practice:

- The initial notation of an abbreviation should be spelled out in full with the abbreviation in parentheses. For example: “Alcohol-related cognitive disorder (ARCD).” Subsequent mention of the condition can then be made using the abbreviation.
- The diagnosis should be spelled out in full in the final impression or plan.

Current versus historical:

- When the condition is current, include it in the final assessment along with the current status.
- Do not use past-tense terms such as “status post” or “history of” to describe a current substance use disorder. In diagnosis coding, conditions described as

“history of” indicate a historical condition that no longer exists as a current problem.

- Do not use “history of” to describe a condition in remission. Instead, document remission.
- For personal history of substance use disorders that are truly resolved, follow the coding path in the ICD-10-CM manual to determine final code assignment.

Followed by a different provider:

When a substance use disorder is being followed and managed by a different provider, it is still appropriate to include the diagnosis in the final assessment when the condition has impact on patient care, treatment and management. Example: “Opioid dependence in sustained remission per records from his treating psychiatrist, Dr. John Williams.”

Electronic medical record (EMR) issues:

- Some electronic medical records (EMRs) insert ICD-10-CM codes with corresponding descriptions into the assessment section of the office note rather than a provider-stated final diagnosis. For example: “F10.288 Alcohol dependence with other alcohol-induced disorder”. This vague description is incomplete, as the “other” alcohol-induced disorder is *NOT* specified.
- Another scenario that causes confusion is when the assessment section documents a provider-stated diagnosis *PLUS* an EMR-inserted diagnosis code with description that does not match – or may even be contradictory.
- **Please note:** ICD-10-CM is a statistical classification; it is not a substitute for a healthcare provider’s final diagnostic statement. It is the provider’s responsibility to provide legible, clear, concise and complete documentation of a final diagnosis described to the highest level of specificity, which is then translated to a code for reporting purposes. It is not appropriate for healthcare providers to simply list a code number or select a code number from a list of codes in place of a written final diagnosis.

Treatment plan

Document a clear and concise treatment plan, for example:

- Referrals (e.g., individual/family counseling; support groups or 12-step program; inpatient/outpatient rehabilitation).
- Urine and blood toxicology and other diagnostic testing.
- Clear linkage of substance use disorder to any medications being used to treat the condition.
- Date or time frame for next appointment.

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Tips and resources for coders

Coding basics

To ensure accurate and specific diagnosis code assignment:

- Review the entire medical record to verify the substance use disorder is current.
- Note the exact description of the substance use disorder that is documented in the medical record. Then, in accordance with ICD-10-CM official coding conventions and guidelines:
 - Search the alphabetic index for that specific description.
 - Verify the code in the tabular list, carefully following all instructional notes as appropriate.

Coding substance use disorders

In the ICD-10-CM coding manual, substance use disorders classify to Chapter 5: Mental, Behavioral and Neurodevelopmental disorders. Mental and behavioral disorders due to psychoactive substance use classify to categories F10-F19. Additional characters are added to provide greater specificity and to complete the code.

- F10.- Alcohol related disorders
- F11.- Opioid related disorders
- F12.- Cannabis related disorders
- F13.- Sedative, hypnotic or anxiolytic disorders
- F14.- Cocaine related disorders
- F15.- Other stimulant related disorders
- F16.- Hallucinogen related disorders
- F17.- Nicotine dependence
- F18.- Inhalant related disorders
- F19.- Other psychoactive substance related disorders

Remission:

- Selection of codes for “in remission” requires the provider’s clinical judgment. Coders are not allowed to clinically interpret documented time frames to decide on their own that the condition is in remission. The appropriate codes for “in remission” are assigned only on the basis of specific provider documentation (as defined in the Official Guidelines for Coding and Reporting), *unless otherwise instructed by the classification or the coding path leads to remission.*
- **Mild** substance use disorders in early or sustained remission are classified to the appropriate codes for substance **abuse** in remission.
- **Moderate or severe** substance use disorders in early or sustained remission are classified to the appropriate codes for substance **dependence** in remission.

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:

- 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.

Psychoactive substance use, unspecified:

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 ICD-10-CM Official Guidelines for Coding and Reporting, Section III, Reporting Additional Diagnoses). These codes are to be used only when the psychoactive substance use is associated with a physical, mental or behavioral disorder and such a relationship is documented by the provider.

Alcohol use with no further specification:

Alcohol use with no further specification codes to Z72.89, Other problems related to lifestyle.

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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.
Final diagnosis	<ol style="list-style-type: none"> 1. Hypertension, stable. Continue same medication. 2. Low back pain, stable. 3. Opioid use – doing better since decreasing pain medication intake. Previous complaint of lightheadedness has resolved.
ICD-10-CM code(s)	<p>I10 Essential (primary) hypertension</p> <p>M54.5 Low back pain</p> <p>Z79.891 Long-term (current) use of opiate analgesic</p>
Comments	Code F11.90 Opioid use, unspecified, uncomplicated is not assigned for prescribed opioid use as described in this record. Without documentation of an associated physical, mental or behavioral disorder, code F11.90 is not appropriate. Long-term opioid use is reported with code Z79.891. Reference: AHA Coding Clinic, Prescribed opioids for pain management, second quarter 2018, Pages 11-12

Example 2	
Medical record documentation	23-year-old male brought to the emergency department by his roommate. They hosted a drinking party at their apartment and 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 22/100 ml. Admitted to 12 East.
Final diagnosis	Acute alcohol intoxication
ICD-10-CM code(s)	<p>F10.129 Alcohol abuse with intoxication, unspecified</p> <p>Y90.1 Blood alcohol level of 20-39 mg/100 ml</p>
Comments	Category F10, Alcohol related disorders, advises to “Use additional code for blood alcohol level, if applicable (Y90.-)”

Example 3	
Medical record documentation	32-year-old white 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.
Final diagnosis	Marijuana use withdrawal
ICD-10-CM code	F12.93 Cannabis use, unspecified with withdrawal
Comments	Code F12.93 is used to report cases of physiological withdrawal from cannabis occurring in a person who is using cannabis regularly but not described as cannabis dependence.

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Tips and resources for coders

Example 4	
Medical record documentation – Primary Care Physician (PCP)	48-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”.
Final diagnosis	Alcoholic gastritis, improved. Continue omeprazole 20 mg one capsule daily before breakfast. History of cocaine dependence
ICD-10-CM code(s)	K29.2Ø Alcoholic gastritis without bleeding F1Ø.288 Alcohol dependence with other alcohol-induced disorder F14.21 Cocaine dependence, in remission
Comments	Code K29.2Ø has an instructional note advising to “Use additional code to identify: alcohol abuse and dependence (F1Ø.-).” Following the path in the ICD-10-CM manual, Personal history of cocaine dependence classifies to a remission code as follows: History > personal > drug dependence – see Dependence, drug, by type, in remission. Dependence > cocaine > in remission F14.21.

Example 5	
Medical record documentation	20-year-old male college student presents to the emergency department reporting he has been on Ritalin since age 13 for ADHD. Admits for the past six months he has been experimenting with his dose, sometimes taking a triple dose to help keep him sharp. Now he is losing weight, having erratic sleep patterns and difficulty focusing on anything other than his next Ritalin dose. Patient states, “I need help”. Will admit to observation for complete work-up.
Final diagnosis	Ritalin abuse and dependence Attention deficit hyperactivity disorder
ICD-10-CM code(s)	F15.2Ø Other stimulant dependence, uncomplicated F9Ø.9 Attention-deficit hyperactivity disorder, unspecified type
Comments	In the ICD-10-CM manual appendices Pharmacology List, Ritalin classifies as a CNS stimulant. ICD-10-CM Official Guidelines for Coding and Reporting advise the coder that if both abuse and dependence are documented, assign only the code for dependence.

Example 6	
Medical record documentation	25-year-old female was admitted to inpatient facility for acute respiratory failure due to Percocet abuse with intoxication. The acute respiratory failure and Percocet intoxication resolved after treatment; and she is now being transferred to an inpatient drug rehabilitation facility for treatment of Percocet abuse.
Final diagnosis	Acute respiratory failure due to Percocet abuse with intoxication
ICD-10-CM code(s)	J96.ØØ Acute respiratory failure, unspecified whether with hypoxia or hypercapnia F11.129 Opioid abuse with intoxication, unspecified

References: American Academy of Family Physicians; American Hospital Association (AHA) Coding Clinic; American Psychiatric Association; Cleveland Clinic; ICD-10-CM Official Guidelines for Coding and Reporting; Mayo Clinic; MedlinePlus; MentalHealth.gov; National Alliance on Mental Illness; National Institute of Mental Health; Web MD