Substance use disorders
ICD-10-CM
Clinical overview

Disclaimer

This document is intended for physicians and office staff. The information here is not intended to serve as official coding or legal advice.

All coding should be considered on a case-by-case basis and should be supported by medical necessity and the appropriate documentation in the medical record.

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 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:
- Genetic predisposition
- Peer pressure
- Emotional stress
- Family history of substance use disorders
- Environmental stressors
- Trauma
- Anxiety, depression or other mental health disorders

Substance use disorders and mental health problems

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

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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Subjective

In the subjective section of the office note, 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." Rather, 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. with clear cause-and-effect linkage.

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:
o The initial notation of an abbreviation should be spelled out in full followed by the abbreviation in parentheses. For example: "Alcohol-related cognitive disorder (ARCD)." Subsequent mention of the condition can then be made using the abbreviation.
o 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."

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.

Electronic health record (EHR) issues

Other and unspecified codes with descriptions:
Some electronic health records (EHRs) 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:

"F1Ø.288 Alcohol dependence with other alcohol-induced disorder"

"F1Ø.29 Alcohol dependence with unspecified alcohol-induced disorder"

These are vague descriptions and incomplete diagnoses.

- Codes titled "other" or "other specified" are for use when the medical record provides a specific diagnosis description for which a specific code does not exist.

- The "other" ICD-10-CM code with description should not be used, by itself, as a final diagnosis without clear documentation that specifies the particular "other" condition.

- Unspecified diagnosis descriptors should be used only when sufficient clinical information is not known or available to the provider at the time of the encounter.

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Mismatch between final diagnostic statement and EHR-inserted diagnosis code with description:
Another scenario that causes confusion is when the assessment section documents a provider-stated diagnosis *PLUS* an EHR-inserted diagnosis code with description that does not match – or may even be contradictory.

> **Assessment: Opioid dependence**
> F11.24 Opioid dependence with opioid-induced mood disorder

Here the final diagnosis **in bold** in the Assessment is simply **Opioid dependence**, which codes to F11.2Ø, Opioid dependence, uncomplicated.

The EHR-inserted diagnosis code with description that follows, however, is F11.24 Opioid dependence with opioid-induced mood disorder.

This can lead to confusion regarding which diagnostic statement is correct and which diagnosis code should be reported. Documentation elsewhere in the record does not always provide clarity.

To avoid confusion and ensure accurate diagnosis code assignment, the provider-stated final diagnosis must either
   a) match the code with description; or
   b) it must classify in ICD-10-CM to the EHR-inserted diagnosis code with description.

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 each 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.

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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 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 F1Ø-F19. Additional characters are required to provide greater specificity and to complete the code.

- F1Ø.- Alcohol related disorders
- F11.- Opioid related disorders
- F12.- Cannabis related disorders
- F13.- Sedative, hypnotic, or anxiolytic related 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" for categories F1Ø-F19 requires the provider's clinical judgment and 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.*
- Coders are not allowed to clinically interpret documented time frames to decide on their own that the condition is in 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 (F1Ø.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 substance related disorder included in Chapter 5 of the ICD-10-CM coding manual (such as sexual dysfunction, sleep disorder, or a mental or behavioral disorder) or medical condition, and such a relationship is documented by the provider.

Medical conditions due to psychoactive substance use, abuse and dependence:

Medical conditions due to substance use, abuse and dependence are not classified as substance-induced disorders. Assign the diagnosis code for the medical condition as directed by the Alphabetical Index along with the appropriate psychoactive substance use, abuse or dependence code. For example, for alcoholic pancreatitis due to alcohol dependence, assign the appropriate code from subcategory K85.2, Alcohol induced acute pancreatitis, and the appropriate code from subcategory F1Ø.2, such as code F1Ø.2Ø, Alcohol dependence, uncomplicated. It would not be appropriate to assign code F1Ø.288, Alcohol dependence with other alcohol-induced disorder.

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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. 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. (References: Substance abuse/dependence with anxiety, mood disorder, sleep disorder or sexual dysfunction, First Quarter 2022, Page 34 and Anxiety with alcohol abuse, First Quarter 2022, Pages 33-34)

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 diagnoses	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 code(s)	I1Ø Essential (primary) hypertension M54.5Ø Low back pain, unspecified Z79.891 Long-term (current) use of opiate analgesic
Comments	▪ 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. ▪ 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)	F1Ø.129 Alcohol abuse with intoxication, unspecified Y9Ø.1 Blood alcohol level of 20-39 mg/100 ml
Comments	Category F1Ø, Alcohol related disorders, advises to "Use additional code for blood alcohol level, if applicable (Y9Ø.-)"

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Example 3	
Medical record documentation	32-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.
Final diagnosis	Marijuana use withdrawal
ICD-10-CM code(s)	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 in contexts that are not defined as cannabis dependence.

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 diagnoses	Alcoholic gastritis, improved. Continue omeprazole 20 mg one capsule daily before breakfast. Alcohol dependence History of cocaine dependence
ICD-10-CM code(s)	K29.2Ø Alcoholic gastritis without bleeding F1Ø.2Ø Alcohol dependence, uncomplicated 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, "Alcohol dependence" with no further specification codes to F1Ø.2Ø and cocaine dependence in remission codes to 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 diagnoses	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 central nervous system (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.

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

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