Documentation and Coding Tips

Substance Disorders: Use, Abuse, Dependence, Remission

Substance disorders are increasingly diagnosed and treated by the patient's primary care provider. These conditions are divided into four categories of use, abuse, dependence, and remission by severity. It's the provider's responsibility to document whether this condition is mild, moderate, or severe. DSM-5 provides further guidance regarding the criteria required for diagnosing the disorder and the patient's current severity.

Use:

- The irregular or low-frequency use of a substance that is not habitual. Typically, not coded unless there is a documented medical concern linked to the use.

Abuse:

- The habitual use of a substance that negatively impacts a patient's health or social functioning but has not arrived at the point of physical and/or mental dependency. The patient has "mild" substance abuse disorder. Mild is the presence of 2-3 symptoms.

Dependence:

- Chronic mental and physical state where the patient must use a substance to function normally. Patients generally experience signs of withdrawal upon cessation of the substance. The patient has "moderate or severe" substance use disorder. Moderate is presence of 4-5 symptoms. Severe is presence of 6 or more symptoms.

In Remission: Requires provider's clinical judgement and documentation if the patient is in remission or not.

Document these key points for the accurate and specific assignment of the correct ICD.10 code(s) for Alcohol, Drug and Substance disorders:

- **Status:** Use, abuse, or dependence.
- **Substance type:** Alcohol, cannabis, opioids, etc.
- **Severity:** Mild, moderate, or severe. (i.e., "Use disorder" is insufficient for proper code assignment).
- **Substance-induced mood/psychotic symptoms:** Depression, hallucinations, anxiety, etc.
- **Current complications/presentation:** Intoxicated, drunkenness, withdrawal, sleep disorder, etc.
- **History/pattern of use:** Continuous use, in remission, relapsed, etc.
  - Do not use the word "history" if the condition is still active.
- **Treatment plan:** Counseling, rehabilitation, maintenance therapy (specify drug), Alcoholic Anonymous (AA), etc**.**

Documentation and Coding Examples:

Nonspecific Example:
Patient is being admitted to the treatment center with a history of opioid dependence

Rationale: If the patient is being admitted, it seems unlikely this patient is in remission but, by stating "history of", this is what is documented. Patient has opioid dependence, not a history of opioid dependence.

Specific Example:
Patient is being admitted to the treatment center for treatment of opioid dependence. She has been an IV heroin user for five years.

Rationale: Documentation quantifies the time the patient has been an opioid user without making the mistake of using "history of".

*Per ICD.10, if the provider documents use, abuse, or dependence of the **same substance**, only one code should be assigned to identify the pattern of use based on the below hierarchy.*

Documented	***Assign Only***
Use and abuse	*Abuse*
Abuse and dependence	*Dependence*
Use, abuse, and dependence	*Dependence*
Use and dependence	*Dependence*