April is Alcohol Awareness Month
April 2015

Insider

Informative and educational coding information for providers

Focus on: Alcohol dependency

Substance abuse, particularly of alcohol and prescription drugs, among adults 60 and older is one of the fastest-growing health problems facing the country. Yet the situation remains underestimated, underidentified, underdiagnosed and undertreated. Until relatively recently, alcohol and prescription drug misuse, which affects up to 17% of older adults, was not discussed in either the substance abuse or the gerontological literature.[1]

Alcohol abuse

In a study of community-dwelling persons 60 to 94 years of age, 62% of the subjects were found to drink alcohol, and heavy drinking was reported in 13% of men and 2% of women; moreover, overall, about 6% of older adults are considered heavy users of alcohol.[2] Based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), the Centers for Medicare & Medicaid Services (CMS) will reimburse for an alcohol misuse screening and up to four Intensive Behavioral Therapy (IBT) sessions for those who have screened positively for alcohol misuse.[3] Finally, the USPSTF prefers the following tools for alcohol misuse screening in the primary care setting: the Alcohol Use Disorders Identification Test (AUDIT), AUDIT-C or a single-question screening (i.e., "How many times in the past year have you had four [or all adults older than 65 years] or more drinks in a day?").[4]

Substance abuse/Prescription drug abuse

Older patients are prescribed benzodiazepines more than any other age group, with benzodiazepines accounting for 17-23% of all drugs prescribed to older adults.[5] The dangers associated with these drugs are the result of age-related changes in drug metabolism, interactions among prescriptions and interactions with alcohol. Unfortunately, these agents, especially those with longer half-lives, often result in unwanted side effects that influence functional capacity and cognition, which place the older person at greater risk of falling and institutionalization.[6] Drug related delirium or dementia can be misdiagnosed as Alzheimer's disease. Accordingly, primary care physicians should review all medications and consider discontinuing any medications that fall within Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.[7]

Always remember...

- Document the substance the patient is dependent on (e.g., alcohol, opioid, sedative)
- Document the status of the condition
- Personal history of alcohol/drug dependence is reported as dependence in remission

Documentation and coding tips

ICD-9-CM[8]

303.xx Alcohol dependence syndrome

Use an additional code to identify any associated physical complication of alcohol, such as: cirrhosis of liver (**571.2**), gastritis (535.3), hepatitis (571.1), liver damage NOS (**571.3**).

303.0x Acute alcoholic intoxication

303.9x Other and unspecified alcohol dependence

Chronic alcoholism

The fifth digit subclassification identifies the status of the condition as unspecified, continuous, episodic or in remission.

Example: **303.93** Other and unspecified alcohol dependence, in remission.

ICD-10-CM[9]

F10.2 Alcohol dependence

Use an additional code for blood alcohol level, if applicable (Y90.-). The physician must document the blood alcohol level in the progress note.

Codes in this category specify dependence with: intoxication, withdrawal, alcohol-induced mood disorders, psychotic disorders, persisting amnestic disorders, alcohol-induced persisting dementia, other and unspecified alcohol-induced disorders.

Example: F10.231 Alcohol dependence with withdrawal delirium

F11-F19 Drug Related Disorders

Each category includes the character .2- to identify drug dependence. The DSM-5[10], released in 2013, details the diagnostic criteria for opioid use disorder and specifically states "*Note: This criterion is not considered to be met for individuals taking opioids solely under medical supervision.*" The diagnostic criteria for sedative, hypnotic or anxiolytic use disorder includes the same note.

1. Center for Substance Abuse Treatment. Substance Abuse Among Older Adults. Rockville (MD): Substance Abuse and Mental Health Services Administration (U.S.); 1998. (Treatment Improvement Protocol (TIP) Series, No. 26.) Chapter 1–Substance Abuse Among Older Adults: An Invisible Epidemic. ncbi.nlm.nih.gov/books/NBK64422/.
2. National Institute on Alcohol Abuse and Alcoholism. Alcohol and Aging. Alcohol Alert 2:1–5. 1988.
3. "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse." Centers for Medicare & Medicaid Services. Department of Health and Human Services, 23 Nov. 2011. Web. 13 Oct. 2014. cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7633.pdf
4. Jonas DE., Garbutt JC., Brown JM., et al. Screening, Behavioral Counseling, and Referral in Primary Care to Reduce Alcohol Misuse [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (U.S.); 2012 July. (Comparative Effectiveness Reviews, No. 64.) ncbi.nlm.nih.gov/books/NBK99199/
5. D'Archangelo, E. Substance abuse in later life. Canadian Family Physician 39:1986-1993. 1993.
6. Roy, W., and Griffin, M. Prescribed medications and the risk of falling. Topics in Geriatric Rehabilitation. 1990;5(20):12–20.
7. "American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." *The American Geriatrics Society 2012 Beers Criteria Update Expert Panel*, 23 Nov. 2011. Web. 13 Oct. 2014. americangeriatrics.org/files/documents/beers/2012BeersCriteria_JAGS.pdf
8. *Optum ICD-9-CM Professional for Physicians 2015.* Vols 1&2. Salt Lake City: 2014.
9. *Optum ICD-10-CM: The Complete Official Draft Set 2015.* Salt Lake City: 2014.
10. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

Per the ICD-10-CM Official Guidelines for Coding and Reporting 2015 from the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS): "A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required."