Treating Opioid Use Disorder as a Chronic Condition

A PRACTICE MANUAL FOR FAMILY PHYSICIANS

Contributing Authors:
Thomas Baker, B.A.
Genevieve Verrastro, M.D., FAAP
Amy Marietta, M.D., M.P.H., FAAFP, FASAM
Justin Riederer, M.D.
E. Blake Fagan, M.D.
Carriedelle Fusco, M.S.N., FNP-BC

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Introduction

In 2023, 8.9 million Americans 12 years or older misused opioids.[1] An estimated 5.7 million had an opioid use disorder, 5.3 million had a prescription pain reliever use disorder, 587,000 had a heroin use disorder and 828,000 misused fentanyl. Increasingly, the presence of illicit fentanyl or fentanyl-laced drugs and fake prescription pills that are highly potent pose a significant overdose risk to users, with their prevalence a major public health concern in the United States. Illicit fentanyl use is likely underreported in the drug supply, with many users unaware they are consuming fentanyl-laced pills. Of further concern is that among the 5.7 million individuals with an OUD in 2023, only 18% received medication-assisted treatment, leaving a significant gap for individuals in need of treatment.

There is abundant evidence for, and the U.S. Food and Drug Administration supports, the use of medication for OUD, called MOUD, as a first-line treatment as part of a comprehensive primary care practice to address opioid dependence.[2] The FDA states that the "treatment for OUD is most effective when medications are used" and "treatment of OUD with medications reduces opioid misuse and the risks of overdose, return to use and death compared with those receiving no treatment." Behavioral health services should also be offered to patients with OUD whenever possible. However, the absence of these services should not prevent the dispensing of MOUD.

MOUD improves mortality, treatment retention and remission,[3] but only a fraction of eligible patients get treatment.[4] Evidence-based treatment medications include buprenorphine, methadone and naltrexone, allowing patients an opportunity to enter active recovery.[5]

Family physicians and other primary care clinicians are in an ideal position to integrate early substance use disorder prevention and treatment. These include screening, brief intervention and referral to treatment, called SBIRT, for OUDs and providing MOUD.[6] By doing so, family physicians and other clinicians play a critical role in preventing and treating OUDs.

This practice manual provides guidance for incorporating evidence-based treatments and opioid SBIRT into primary care practice.

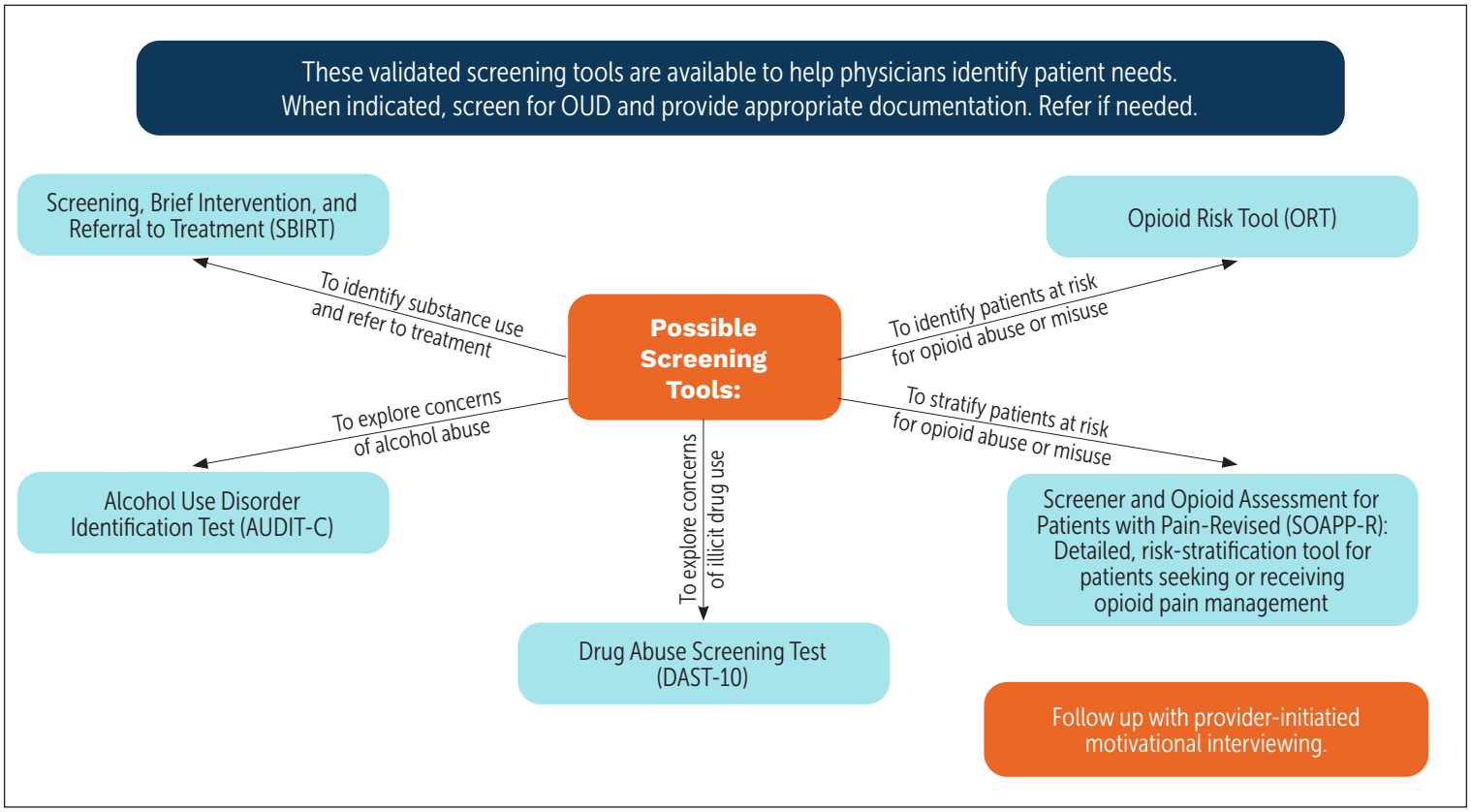
Screening

Many professional organizations, including the American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American Academy of Addiction Psychiatry, American Society of Addiction Medicine and U.S. Preventive Services Task Force, recognize the importance of selective SBIRT and behavioral counseling to reduce opioid misuse and abuse.[7]

After identifying patients to screen, standardize your process for SBIRT. Most electronic health records allow for integration of the OUD protocol into the practice workflow, facilitating system-level changes to address OUD. Prompts on face sheets or summary screens can quickly identify patients with an OUD. The U.S. Department of Health and Human Services guide, Screening and Assessment for Family Engagement, Retention and Recovery, details numerous screening tools.[8]

The graphic below contains approaches and validated screening tools to identify patients needing further treatment. Begin with the SBIRT and utilize other options for the patient and situation (e.g., Opioid Risk Tool to identify patients at risk for opioid abuse or misuse; Screener and Opioid Assessment for Patients with Pain-Revised for patients in need of pain management; Drug Abuse Screening Test for patients with possible illicit drug use).

Figure 1. Screening Tools for Opioid Use Disorder and Substance Use Disorders[6, 9-13]



IDENTIFY AND OVERCOME BARRIERS TO SCREENING

When screening patients for OUD, there might be multiple challenges. For many physicians, common barriers to implementing and promoting SBIRT and OUD treatment include:

- Ongoing stigma and bias regarding the treatment of OUD.
- Inadequate training for clinicians to comfortably treat OUD in the office setting.
- Lack of knowledge and understanding of OUD diagnostic criteria, assessment and treatment options.
- Patients may be uncomfortable disclosing their substance use. A curious and nonjudgemental approach can be valuable in developing an open dialogue.

WORDS MATTER

Treating patients respectfully strengthens the physician-patient relationship and empowers patients to actively participate in developing and successfully implementing their treatment plans. The language used by physicians and other clinicians is important, with terminology continually evolving. For a comprehensive and up-to-date list of terms to use when discussing OUD with patients, refer to TIP 63: Medications for Opioid Use Disorder, which includes key terms used in treating patients with an OUD. Below is a comparison between outdated language and more accurate, recommended terminology.[14-17]

No longer recommended language	Recommended language
Addict	Person with a use disorder/person who uses drugs
Clean urine/dirty urine	Urine as expected/urine as unexpected
Detoxification	Withdrawal management
Addicted baby	Neonatal Opioid Withdrawal Syndrome
Relapse	Return to use

ADDRESSING STIGMA AND BIAS

Patients with an OUD are part of a marginalized community that faces significant stigma and bias. Family physicians and their care teams must consider the social and structural determinants that influence health and well-being while addressing the potential implicit bias toward patients with an OUD. Implicit bias is "the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner."[18] The AAFP offers additional resources and training on implicit bias through its EveryONE Project.[19]

Physicians and other clinicians should frame OUD as a chronic, relapsing disease, such as diabetes, hypertension or asthma.[20] In managing long-term OUD care, treatment should continue for as long as it benefits the patient. Just as a patient with diabetes may need lifelong medication to manage their condition, a patient with an OUD may require MOUD to manage their disorder effectively throughout their life.

EQUITY CONSIDERATIONS

The minority stress hypothesis posits that increased chronic stress and trauma faced by minority populations could lead to increased substance use and worse mental and other health outcomes.[21] Providers should be aware of these disparities and actively work to address them in their practices.

After consistent and steady increases in deaths from opioid overdoses for two decades,[22] the rate of death decreased in 2023 for all populations for the first time in more than 20 years.[23] However, the extent of that decrease was uneven across demographic groups, with death rates the highest among Black and American Indian and Alaska Native populations.

One reason for this disparity is that SUD treatment is consistently offered less frequently and used less often by racial minorities.[24] This is often due to stigma and negative stereotyping, lack of culturally competent and respectful care, fewer treatment options in minority neighborhoods and fear of legal repercussions stemming from a justified mistrust of the health care, social service and justice systems.[25]

When patients from minority backgrounds do seek care, they are less likely to have access to the full range of evidence-based and less stigmatizing treatment for SUD/OUD. One study found that areas with the highest proportion of Black and Hispanic low-income individuals had the highest rate of methadone treatment. In contrast, areas with the greatest proportion of white high-income individuals had greater access to buprenorphine and naloxone. Generally, buprenorphine and naloxone are a less stigmatizing treatment option to treat SUDs when compared to methadone.

Likewise, lesbian, gay or bisexual individuals have consistently higher rates of OUD or other SUD compared to heterosexual individuals.[26] Data on transgender or gender-diverse patients on this topic is less available, but they also experience higher rates of SUD.[27]

While these issues may seem daunting to the individual provider, the following steps can improve cultural competency and diversity in practice[28]:

- Incorporating diversity, equity and inclusion principles into organizational policies at all levels.
- Training in DEI for all staff, administrators and providers.
- Hiring of diverse staff and providers.
- Using inclusive and non-stigmatizing language in oral and written communication, including patient forms and EHRs.
- Advocating for policy changes at local, state and national levels by offering testimony to your elected officials that OUD is a chronic, relapsing disease instead of a criminal matter.
- Partnering with individuals and organizations promoting recovery and wellness for at-risk populations.

Diagnostic Criteria and Assessment

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition, Criteria for Diagnosis of Opioid Use Disorder contains specific criteria and classification of OUD (mild, moderate or severe) depending on the number of symptom boxes checked for patients.[29]

The DSM-5 includes elements of tolerance, dependence, loss of control and personal consequences of opioid use. Properly assess patients with a possible OUD by[14]:

- Documenting that the patient meets the criteria for an OUD with a current opioid use history.
- Documenting the patient's use of alcohol and other drugs and the need for medically supervised withdrawal management.

- Identifying the patient's comorbid medical and psychiatric conditions and determining how, when and where they will be addressed. However, the lack of access to adequate mental health treatment should not preclude access to MOUD.
- Evaluating the patient's physical, psychological and social functioning or impairment.
- Determining the patient's readiness to participate in treatment.
- Screening for and addressing communicable diseases, such as sexually transmitted infections, HIV, hepatitis B and hep C.

Treating Opioid Use Disorder

MEDICATIONS FOR OPIOID USE DISORDER

A common misconception associated with MOUD is that it substitutes one drug for another.[30] Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the brain. MOUD programs provide a safe and controlled level of medication to overcome the use of an abused opioid. Individuals may safely take medications used in MOUD for months, years or even a lifetime.

There are three FDA-approved medications for treating OUD: methadone, buprenorphine and naltrexone. Consider how these treatments align with the resources at your clinic and its patient population. In addition to the evidence-based treatments noted above, naloxone should be prescribed for all patients at risk of overdose, including patients with OUD and those prescribed opioids for acute or chronic pain.[31] While naloxone is not used alone to treat OUD, it is commonly prescribed alongside buprenorphine for use in case of an overdose. This section reviews these medications, their uses, benefits, risks and potential side effects. A table at the end of this section summarizes methadone, buprenorphine and naltrexone.

Methadone

Methadone is a long-acting, full opioid agonist approved by the FDA for the treatment of OUD and chronic pain.[32] It is a Schedule II-controlled medication that reduces opioid withdrawal symptoms and cravings. When taken as prescribed, methadone is a safe and effective form of MOUD, which helps individuals dependent on opioids achieve sustained recovery and reduce the risk of overdose.

Methadone Potential Risks and Considerations

As a full agonist opioid, methadone presents a potential risk of respiratory depression and overdose if not dosed correctly or taken as prescribed.[14] Like other opioids, methadone has the potential to cause nausea, vomiting and constipation. Due to the long and variable half-life of methadone, patients face an increased risk of fatal respiratory depression due to overdose, as well as the risk of QT interval prolongation. Therefore, methadone should only be prescribed by experienced health care providers. It can only be dispensed by a Substance Abuse and Mental Health Services Administration-certified opioid treatment program for OUD.

While methadone prescribed for chronic pain in outpatient settings is not subject to OTP guidelines, the associated risks remain the same. If prescribing methadone, physicians should be aware of other medications the patient is taking. Advise them of the risks of taking methadone with other substances of abuse, such as alcohol, sedatives and tranquilizers, due to the risks of respiratory depression.

According to the SAMSHA Federal Guidelines for OTPs, the recommended total methadone dose "for the first day should not exceed 50 milligrams unless the OTP practitioner, licensed under the appropriate state law and registered under the appropriate state and federal laws to administer or dispense MOUD, finds sufficient medical rationale, including but not limited to if the patient is transferring from another OTP on a higher dose that has been verified, and documents in the patient's record that a higher dose was clinically indicated."[33] Reassessment on the first day should occur 2-4 hours after the initial dose.

Patients using a higher potency of synthetic opioids, like fentanyl, will likely need a higher initial dose.[34] Methadone doses for these patients may need to be 100 mg or higher, as needed. There is no official upper limit, as OTP providers must carefully balance the benefits and risks of dose adjustments to achieve the lowest dose for optimal effectiveness. Dosage requirements vary among patients, with some responding well to lower doses and others requiring higher doses to manage cravings. Starting doses may be increased by 10-15 mg increments every three to five days. This is necessary to avoid oversedation, toxicity or iatrogenic overdose deaths.[35]

Buprenorphine

As a partial opioid agonist, buprenorphine helps control cravings.[36] It prevents symptoms of opiate withdrawal while partially blocking the action of opiate agonists, such as fentanyl, heroin and prescription opioids, decreasing the risk of overdose.[37] It is a Schedule III-controlled medication.[33] If used correctly, even high doses of buprenorphine are not associated with higher levels of respiratory depression, making this medication significantly safer than full agonist opioids. Buprenorphine can also treat pain in different formulations.

Buprenorphine Potential Risks and Considerations

Any prescriber with a Drug Enforcement Administration license can prescribe buprenorphine.[38] The goal when prescribing is not to keep a patient on the lowest dose. Rather, it is to find an adequate dose to treat the patient's cravings and withdrawals. When taking buprenorphine, physicians should be aware of other medications the patient is taking. Advise them of the risks of co-using substances of abuse, such as alcohol, sedatives and tranquilizers, due to the risks of respiratory depression.[33] As buprenorphine is hepatically metabolized, monitor any severe liver-related health issues the patient may have, such as cirrhosis or hepatitis.[39,40]

Buprenorphine Diversion and Misuse

Buprenorphine has a potential for misuse due to its opioid properties,[36] but concerns about its misuse may be misguided. A combination product containing buprenorphine and naloxone was designed to reduce the risk of diversion and misuse. It was based on the premise that buprenorphine was well-absorbed via the sublingual route, while naloxone was not. If the combination product is dissolved and injected, naloxone becomes active, inducing precipitated withdrawal and thereby potentially discouraging injection use.[41] However, emerging evidence suggests that naloxone may be absorbed sublingually to a greater extent than previously thought, raising questions about potential side effects.[42] Additionally, the potential benefits of decreased misuse and diversion may not outweigh the consequences of limiting access to MOUD. Lack of access to the combination product should not prevent prescribers from prescribing the monoproduct for OUD.[43]

Buprenorphine medications are occasionally diverted, but a recent study found that most diverted buprenorphine is used to manage withdrawal symptoms (79%), maintain abstinence (67%) or self-taper off opioids (53%).[44] This study suggests that the barriers to accessing the treatment of OUD partially drive the diversion of buprenorphine.

Naltrexone

Naltrexone is not classified as a controlled substance, and therefore, any licensed physician with a prescribing authority can prescribe it.[45] The long-acting injectable formulation requires a risk evaluation and mitigation strategy to ensure that the benefits of the drug outweigh its risks. Naltrexone can be used to treat OUD and alcohol use disorder. The oral formulation taken daily treats AUD, while the injectable is for either an AUD or OUD and is administered every four weeks by a practitioner. Naltrexone is considered second-line therapy for OUD after methadone and buprenorphine. It is a full opioid antagonist at the opioid receptor, blocking the effect of other opioids and potentially reducing cravings.[46,47] Abuse and diversion potential with naltrexone is limited, if any. If a patient returns to use while on the medication, naltrexone prevents all the effects of the illicit opioid.

Naltrexone Potential Risks and Considerations

Warn patients to abstain from all opioids at least 7-10 days before starting injectable naltrexone to lower the chance of acute withdrawal.[48] The requirement of a 7-10 day abstinence period can significantly hinder adherence to and follow up on naltrexone treatment. Patients discontinuing the use of naltrexone experience a reduced tolerance to opioids.[47] They may be unaware of their increased sensitivity to the same or even lower doses of opioids than previously used. If they return to opioid use after a period of abstinence, the loss of tolerance may result in life-threatening complications, such as respiratory depression or circulatory collapse, even at previously tolerated doses.[47,49]

Naloxone

Naloxone is an FDA-approved medication for the reversal of acute respiratory depression caused by an opioid overdose.[50] It can be administered through an intranasal spray, intramuscular, subcutaneous or intravenous injection to help reverse an opioid overdose. According to the World Health Organization, naloxone is considered an essential medication for a functioning health care system.[51]

Physicians should ensure naloxone is readily accessible to patients at risk of opioid overdose, as well as their families and caregivers. When prescribing opioid medications or initiating treatments for OUD, co-prescribing naloxone is strongly recommended to mitigate the risk of overdose.[52,53] Physicians should educate patients on the purpose, proper use and administration of naloxone, emphasizing its role as a life-saving intervention. Efforts should also be made to integrate naloxone distribution into clinical workflows and community programs to enhance its availability and reduce barriers to access.

Patients Who are Pregnant and/or Breastfeeding or Chestfeeding

Providers should screen all pregnant patients for SUDs with a validated verbal screening tool.[54] Urine toxicology tests alone are not validated screening tools. In its joint opinion on opioid use and OUD in pregnancy, the ACOG and ASAM recommend relying on validated screening tools, such as the 5Ps for Substance Abuse for pregnant patients (Pregnancy, Peers, Past, Partner and Parents), National Institute on Drug Abuse Quick Screen and CRAFFT. If urine toxicology tests are used for analysis, patients should receive clear and complete information about the purpose of the test, potential benefits and risks, use of the results and their right to refuse the test.

Untreated OUD during pregnancy leads to an increased likelihood of adverse maternal-fetal and maternal-infant health outcomes, including an increased risk of low birth weight for newborns, intrauterine growth restriction and placental changes.[55] There is also an increased risk of stillbirth, preterm labor and even death.[56]

Methadone and buprenorphine are considered the standard of care for pregnant patients with an OUD.[57,58] To improve outcomes for pregnant people with OUD and their newborns, the AAFP has supported the ASAM public policy statement on SUD among pregnant and postpartum people that states that providers should[59]:

- Screen all pregnant patients for SUDs with a validated verbal screening tool.
- Encourage and prescribe medications for OUD during pregnancy, such as buprenorphine or methadone. Pregnant patients face additional barriers to receiving evidence-based treatment for OUD, and prenatal care providers can help bridge this gap.
- Offer trauma-informed, whole-person care, including screening and treatment for co-occurring mental health conditions and STIs.
- Ensure pregnant patients have access to harm reduction services, such as naloxone for overdose prevention, syringe services programs and peer support and wrap-around care to address social barriers to treatment.

Infants born to patients with OUD may develop neonatal abstinence syndrome.[60] This is an anticipated and treatable condition that presents in about 30-80% of newborns exposed to opioids, including those prescribed MOUD. Neonatal abstinence syndrome, or NAS, is a broad term to describe the group of conditions a baby may develop due to withdrawal from substances, while neonatal opioid withdrawal syndrome, or NOWS, refers to a group of symptoms a baby may develop due to withdrawal from opioids specifically.[57] The eat, sleep and console is an evidence-based approach to diagnose and treat NOWS, and it has been shown to reduce the length of hospital stays and the use of pharmacological treatment for infants with NOWS.[61]

Breastfeeding or chestfeeding is recommended for patients who are stable on their opioid agonists, are not using illicit drugs and have no other contraindications.[60] It has been shown to reduce the length of hospital stays, decrease the severity of NOWS in newborns and decrease the need for pharmacological interventions in infants diagnosed with NOWS.[62] For more guidance on the treatment of pregnant people with OUD, visit the Substance Abuse and Mental Health Services Administration's Advisory Evidence-based, Whole-person Care for Pregnant People Who have Opioid Use Disorder.

Comparing Medications for Opioid Use Disorder

The tables below compare methadone, buprenorphine and naltrexone for dosage, adverse effects, contraindications and other information pertinent to treating OUDs. It uses information from an *American Family Physician* journal article and the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.

Table 1. Comparison of Methadone, Buprenorphine and Naltrexone for Opioid Use Disorders[63,64]

	Methadone (Schedule II)	Buprenorphine (Schedule III)	Naltrexone
FDA-approved formulations with the recommended doses	Tablet: 5 mg, 10 mg Dispersible tablet: 40 mg Oral solution: 5mg/5mL, 10 mg/5mL	Buprenorphine (monoproduct) sublingual tablet (SL tab): 2 mg, 8 mg Buprenorphine (bup)/naloxone (nalox) SL tab: 2 mg bup/0.5 mg nalox 8 mg bup/2 mg nalox Buprenorphine/naloxone (Zubsolv®) SL tab: 1.4 mg bup/0.36 mg nalox 2.9 mg bup/0.71 mg nalox 5.7 mg bup/1.4 mg nalox 8.6 mg bup/2.1 mg nalox 11.4 mg bup/2.9 mg nalox Buprenorphine/naloxone (Suboxone®) SL film: 2 mg bup/0.5 mg nalox 4 mg bup/1 mg nalox 8 mg bup/2 mg nalox 12 mg bup/3 mg nalox Buprenorphine HCL/naloxone HCL (Bunavail®) buccal film: 2.1 mg bup/0.3 mg nalox 4.2 mg bup/0.7 mg nalox 6.3 mg bup/1 mg nalox Equivalent dosages in mg/mg Zubsolv/Suboxone/Bunavail: 1.4/0.36; 2/0.5; 2.1/0.3 2.9/0.71; 4/1; 4.2/0.7 5.7/1.4; 8/2; 6.3/1 8.6/2.1; 12/3; 11.4/2.9 Buprenorphine (Sublocade®) long-acting injection (Rx): 100 mg/0.5 mL prefilled syringe 300 mg/1.5 mL prefilled syringe Buprenorphine (Brixadi®) long-acting injection (Rx): Weekly: 8 mg, 16 mg, 24 mg, 32 mg Monthly: 64 mg, 96 mg, 128 mg	Naltrexone (Depade® and ReVia®) Oral tablet: 50 mg Naltrexone (Vivitrol®) XR depo: 380 mg

Table 2. Comparison of Methadone, Buprenorphine and Naltrexone for Opioid Use Disorders[63,64]

	Methadone (Schedule II)	Buprenorphine (Schedule III)	Naltrexone (IM)
Pharmacology	Full agonist	Partial agonist	Full antagonist
Dosing	Daily (but duration often longer)	Daily/weekly/monthly	Every four weeks
Setting	Specialty licensed OTP	Office-based or OTP; requires a DEA license	Any medical setting; requires an injection
Induction	There is no time restriction; start low, go slow	Mild to moderate withdrawal: greater than 8-12 hours after the last opioid was used; dependent on the strength of opioid use	Greater than seven days after the last opioid was used
Effectiveness	Most studies compared buprenorphine and naltrexone. Treatment retention is superior to low-dose buprenorphine; is equivalent to high-dose buprenorphine. Associated with decreases in opioid use, HIV transmission, risky behaviors and mortality (i.e., all-cause mortality is three times higher when methadone is stopped).	At doses greater than 16 mg, treatment retention is equivalent to methadone and higher than naltrexone. All-cause mortality was reduced by 50%. It is much more effective than a placebo at treatment retention (risk ratio = 1.82) and decreased illicit opioid-positive urine samples.	It is the least well-studied compared with methadone and buprenorphine. The oral form is not FDA-approved for MOUD. The monthly intramuscular form has better treatment retention than nonpharmacologic therapies but has the lowest treatment retention of the three medication options. Patients who successfully complete the induction phase may have treatment retention similar to those on buprenorphine. It has not been shown to decrease all-cause or drug-specific mortality.
Adverse effects	• Sedation • Constipation • Hypogonadism • Prolonged QT interval • Overdose is possible at high doses or in combination with other drugs	• Sedation is rare • Headache • Nausea • Constipation	• Injection site reactions are potentially severe • Headache • Depression • Insomnia • Increased alanine aminotransferase • Increased creatine phosphokinase • Difficult pain management • Decreased tolerance and may be an increased risk of overdose if a return to use
Contraindications	• Hypersensitivity • Drug-drug interactions • Respiratory depression • Severe bronchial asthma or hypercapnia • Paralytic ileus	Hypersensitivity	• Hypersensitivity reactions to naltrexone, or for injectable, previous hypersensitivity reactions to polylactide-coglycolide, carboxymethylcellulose or any other constituent of the diluent • Patients currently physically dependent on opioids, including partial agonists • Patients receiving opioid analgesics • Patients in acute opioid withdrawal
Location of maintenance treatment	Federally certified OTP	• Primary care clinic • Psychiatric clinic • Prenatal clinic • SUD treatment program • Any outpatient setting	• Primary care clinic • Psychiatric clinic • Prenatal clinic • SUD treatment program • OTP • Any outpatient setting

In 2023, the U.S. Department of Health and Human Services eliminated the Data Waiver (X-Waiver) requirements for prescribing buprenorphine for OUDs, enabling any provider with a valid DEA lilcense to prescribe it.[38] In 2024, HHS further updated regulations governing OTPs and extended telehealth provisions. Comprehensive details regarding the 2024 updates can be found in 42CFR Part 8. Given the evolving nature of medication regulations, providers should consult the Federal Register regularly to remain informed about changes to OUD treatment guidelines and services.

Table 3. Comparison of Methadone, Buprenorphine and Naltrexone for Opioid Use Disorders[63,64]

	Methadone (Schedule II)	Buprenorphine (Schedule III)	Naltrexone
Patient considerations	Withdrawal is not required for treatment initiation. Initially, a patient must be seen daily.	Mild withdrawal is required for treatment initiation, usually with 8-48 hours of abstinence. Patients may need to be seen one to two times per week initially, but later visits may be monthly if the patient progresses.	Patients must completely withdraw from opioids before treatment initiation, usually within 7-14 days of abstinence. Patients may be seen monthly for injections.
Regulatory considerations	It must be administered in an OTP or dispensed to those who are inpatient hospitalized for another diagnosis.	The prescriber must have a DEA license or be providing addiction treatment incidental to hospitalization for another diagnosis.	There are no restrictions on prescribing. It must be stored in a clinic refrigerator and administered by trained staff.
Diversion/misuse	Diversion and misuse are possible.	Diversion and misuse are possible.	No risk
Pregnant patients	Treatment with methadone should be initiated as early as possible during pregnancy.	Buprenorphine (monoproduct or with naloxone) is a recommended treatment during pregnancy.	Not FDA-approved for use in pregnancy. If a patient becomes pregnant while receiving naltrexone, it is appropriate to discontinue the medication if the patient and doctor agree the risk of relapse is low.

FOLLOW UP

In early recovery, consider seeing patients at least weekly. Consider seeing the patient every two to three days if the patient needs more support. Engagement with peer support, recovery groups and behavioral health specialists should be encouraged but are not required. As the patient engages in a collaborative relationship with their clinic, the time between encounters can be increased.[65]

Urine drug testing, or UDT, is a valuable component of managing MOUD. Alongside tools such as the Clinical Opiate Withdrawal Scale and assessing physical withdrawal symptoms, drug testing provides critical information to guide treatment decisions.[66] Like using A1C tests to monitor diabetes care, UDT can help clinicians monitor patients' MOUD progress in the following ways:

- UDT should be non-punitive, serving as a basis for open, nonjudgmental dialogue to support recovery.
- UDT that yield false positives are not confirmatory. If discrepancies exist between test results and patient testimony, a confirmatory test can provide clarity.
- UDT may not test for fentanyl. It is important for clinicians to know what a test includes and doesn't include.

MOUD should be continued while awaiting confirmatory results in most cases, and unexpected UDT should not result in termination from care. Physicians should consider more frequent follow-up visits or a referral to a higher level of care. Additional guidance on UDT is available in the AAFP Chronic Pain Management Toolkit.

RETURN TO USE

When a patient has a return to use, it is important to communicate that they are experiencing a chronic illness, and their return to use is common. Follow these steps to help patients when they return to use[67]:

- Except in rare cases of confirmed diversion, MOUD should generally be continued.
- Emphasize that the treatment team will continue to encourage their recovery. If a return to use occurs, physicians should re-evaluate the care plan and consider dose adjustments or other supports.
- The patient may require a higher level of care or connection with community resources, such as behavioral health services, a therapist or peer support specialist, at your clinic or another.
- Manage the patient's expectations for recovery and provide the next steps for the patient's recovery goals.
- Ensure that the patient has naloxone and access to syringe service programs.

NEW AND EMERGING SUBSTANCES

Fentanyl

Fentanyl is a drug that many providers will be familiar with from its use in hospitals and emergency rooms, but over the last 10 years, fentanyl analogs have become a drug of abuse that presents unique challenges to providers treating addiction.[68] Often, fentanyl is sold as heroin or pressed into pills sold as oxycodone or other pain medications.[69]

It was first detected in illicit drug samples starting in 2015-16, initially on the East Coast and spreading west.[70] Overdoses and related deaths associated with synthetic opiates rose dramatically in that period.

Fentanyl is a synthetic opiate that is not based on any extract of the opium poppy.[69] Significantly, fentanyl and its metabolites are not included in the vast majority of Clinical Laboratory Improvement Amendment-waived urine point-of-care or other rapid drug tests.[71] It can be detected using confirmatory send-out testing. The drug is highly potent and lipid soluble. This allows fentanyl to cross the blood-brain barrier very quickly for fast onset[72] but also leads to accumulation in adipose tissues of the body,[73] meaning that trace amounts of fentanyl metabolites can be detected in confirmatory urine testing for weeks or months after a patient has consumed their last dose.[74]

Starting MOUD for patients using illicit fentanyl can be challenging, but the lethality of fentanyl makes engaging patients in treatment even more crucial. Methadone is an effective treatment option for fentanyl use, and buprenorphine is also effective when initiated carefully.[75]

Buprenorphine induction protocols need to be altered for patients using fentanyl.[76] The drug's retention in adipose stores increases the risk of precipitated withdrawal after the initial buprenorphine dose. Buprenorphine initiation is possible with some changes. For more severe withdrawal symptoms, patients should be instructed to wait longer to initiate buprenorphine. At least 24 hours of abstinence from opiates and a COWs score of 12 or more are often recommended. It is difficult for patients to tolerate longer periods of severe withdrawal. Adjunctive medications such as clonidine 0.1-0.3 mg three times a day (depending on the severity of dependence or anticipated withdrawal) or antiemetics may help during this time.[77]

Patients accustomed to using fentanyl may require higher initial doses of buprenorphine to control cravings and withdrawal symptoms.[78] At least 8 mg is recommended as a first dose, and 16 mg should be considered. Patients routinely need 24 mg of buprenorphine daily and may need 32 mg per day or more to stabilize them early in treatment.[79]

Patients with suspected precipitated withdrawal symptoms who experience rapid worsening of withdrawal shortly after the first buprenorphine dose should be instructed to take another buprenorphine dose of 8-16 mg immediately.[80] While true precipitated withdrawal is probably rare, the risk causes anxiety and treatment reluctance in both providers and patients.

Alternatively, low or 'microdose' induction protocols have been used to introduce buprenorphine gradually with little or no preliminary withdrawal period, but this is primarily used in hospital settings.[81]

Other Concerning Substances

Other adulterants added to substances have been noted in the illicit drug supply recently. The veterinary tranquilizer, xylazine, is now found in illicit opiates, most frequently fentanyl.[82] Xylazine, also known as 'tranq,' is an alpha-2 adrenoreceptor agonist that can cause profound sedation independent of opiates.[83] Although xylazine itself is likely only minimally responsive to naloxone, opioid reversal agents should still be administered in cases of a suspected overdose, with careful monitoring of the patient's blood pressure and respiratory status. Withdrawal from xylazine-adulterated opiates presents with profound anxiety and agitation and prolongs the symptoms of opiate withdrawal. Withdrawal symptoms can sometimes be moderated with alpha-2 agonists, such as clonidine or guanfacine, as well as anxiolytics or sedatives.[84]

Xylazine is also implicated in extremity wounds and necrotizing ulcers in habitual users, thought to be mediated by peripheral vasoconstriction.[85] Although painful and sometimes disfiguring, these wounds respond well to traditional wound care principles and techniques.[86] Regional testing centers monitor the illicit drug supply and provide information on adulterants, and we can expect new substances to be introduced periodically.

BEHAVIORAL HEALTH INTERVENTIONS

The ASAM Criteria guides intervention efforts regarding counseling and behavioral services for a patient with addiction and co-occurring conditions. For patients who have recently experienced an overdose and have no psychosocial support, inpatient services may be needed. If a patient declines inpatient services, day treatment programs or intensive outpatient programs might be helpful.

MOUD should be prescribed regardless of a patient's engagement with behavioral health interventions, and patients should not be denied medication or discharged for declining such services. They can be regularly reminded about available services and may engage in behavioral health at any point while receiving MOUD.

Patients with SUDs are more likely to have been exposed to traumatic events and to develop post-traumatic stress disorder.[87] Some patients' trauma preceded their OUD. Behavioral counseling services are key to treating patients with trauma to process a traumatic experience in a therapeutic space. Two common counseling and behavioral services for patients treated for OUD are intensive outpatient therapy and behavioral health integration.[88]

Intensive outpatient therapy may include individual or group visits.[89] Depending on the social supports available to the patient, this can be an excellent option for patients to have time in therapy and treatment and to be away from using substances while not spending time in an inpatient setting.

Behavioral health integration can include remote collaboration with a psychiatrist or psychiatrist nurse practitioner.[90] The clinician or staff member working under that physician can provide a 20-minute check-in with a patient diagnosed with a behavioral health condition.

Preparing Your Practice

Think about how your practice currently functions so that you can identify small, sustainable changes to integrate OUD screening and/or treatment, as appropriate. Meet with your team to identify potential barriers and ways to overcome them to address OUD in your practice. Remember, family physicians treat chronic diseases well, and OUD is a chronic disease.

Sample Workflow

- ☐ Patient checks in: screening (if self-administered/paper/e-screener)
- ☐ Patient in waiting room: posters, brochures, educational information on walls
- ☐ Nurse checks remaining vital signs and screens patient for OUD in the exam room
- ☐ Patient meets with physician: screen for OUD if not completed previously, counsel patient, develop goals and strategies together and offer treatment options
- ☐ Patient meets with counselor/behavioral health counselor, if avaiable, or care is coordinated and referred to behavioral health counselor
- ☐ Plan for future visits: maintenance of MOUD and counseling, reassess, revisit goals and address other primary care needs
- ☐ Patient leaves

WORKFLOW RECOMMENDATIONS

Tailored Team Approach

There are numerous ways to develop and establish OUD screening and treatment in your family medicine practice. The most important aspect is to get the entire staff, as well as your patients, thinking and talking about how to help patients reduce risky opioid use and engage in treatment. It is helpful to educate all staff on an ongoing basis by offering training (e.g., lectures, workshops, in-service training) on opioid SBIRT and provide continuing medical education credits and other incentives for participation.

Staff members to be considered in your efforts include:

- Health care staff, including physicians, physician assistants and advanced practice nurses
- Peer support specialists
- Behavioral health counselors and specialists
- Pharmacists
- Case managers
- Receptionists and office staff

While the family physician leads the team, each member should know their role in OUD screening and treatment.

As you develop the new workflow for your practice, note who will be performing each step and include checkpoints to ensure a system of change occurs. As you implement SBIRT into your practice, incorporate new tools and resources into your workflow. The AAFP has many of these to help you get started, including toolkits, manuals and CME offerings on our Pain Management & Opioid Misuse webpage.

Payment and Coding

Lastly and importantly, ensure you are reimbursed for the time you and your care team spend with patients on evaluation and treatment for OUD and other SUD. As you make this process more efficient and effective for your practice, include a step for coding for services provided. Payment and coding information for OUD ICD-10 and CPT codes (as of January 2025) can be found in the tables below.[91-97]

Table 4. Office or Other Outpatient Evaluation and Management Visits

99202		Office or outpatient visit, new patient, straightforward medical decision making or at least 15 minutes of total time on the date of service
99203		Office or outpatient visit, new patient, low medical decision making or at least 30 minutes of total time on the date of service
99204		Office or outpatient visit, new patient, moderate medical decision making or at least 45 minutes of total time on the date of service
99205		Office or outpatient visit, new patient, high medical decision making or at least 60 minutes of total time on the date of service
99211		Office or outpatient visit, established patient, may not require the physician or other qualified health care professional
99212		Office or outpatient visit, established patient, straightforward medical decision making or at least 10 minutes of total time on the date of service
99213		Office of outpatient visit, established patient, low medical decision making or at least 20 minutes of total time on the date of service
99214		Office of outpatient visit, established patient, moderate medical decision making or at least 30 minutes of total time on the date of service
99215		Office of outpatient visit, established patient, high medical decision making or at least 40 minutes of total time on the date of service
99417	Commercial	Prolonged outpatient E/M service time beyond the required time for the primary service, each additional 15 minutes; List separately in addition to code for the primary service
G2212	Medicare	Prolonged office or outpatient E/M for services beyond the maximum time of the primary service selected using total time on the date of service; Each additional 15 minutes
G2211	Medicare	Visit complexity inherent to the E/M service associated with medical services that serve as the continuing focal point for all needed health care services and/or medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition; List separately in addition to office or outpatient E/M

Table 5. Urine Drug Screening and Testing

80305	Statutory exclusion CLIA waived test; Requires QW modifier	Presumptive drug test, read by direct optical observation only
G0480	Normally billed by laboratory	Definitive drug test, analyzed using methods able to identify drugs and distinguish between structural isomers; Covers 1-7 drug classes, including metabolites
G0481	Normally billed by laboratory	Definitive drug test, analyzed using methods able to identify drugs and distinguish between structural isomers; Covers 8-12 drug classes, including metabolites
G0482	Normally billed by laboratory	Definitive drug test, analyzed using methods able to identify drugs and distinguish between structural isomers; Covers 15-21 drug classes, including metabolites
G0483	Normally billed by laboratory	Definitive drug test, analyzed using methods able to identify drugs and distinguish between structural isomers; Covers 22 or more drug classes, including metabolites

Table 6. Screening and Brief Intervention

99408	Commercial	Alcohol and/or substance abuse screening with brief intervention services; 15-30 minutes
99409	Commercial	Alcohol and/or substance abuse screening with brief intervention services; Greater than 30 minutes
G2011	Medicare	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., Alcohol Use Disorders Identification Test, Drug Abuse Screening Test), and brief intervention services; 5-14 minutes
G0396	Medicare	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST), and brief intervention services; 15-30 minutes
G0397	Medicare	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST), and brief intervention; Greater than minutes
H0049	Medicaid*	Alcohol and/or drug screening
H0050	Medicaid*	Alcohol and/or drug screening, brief intervention services; Per 15 minutes

**Check with your state Medicaid agency regarding their coding policies.*

Table 7. Office-based Substance Use Disorder Treatment

G2086	Office-based treatment for OUD; At least 70 minutes in the first calendar month, which could include the development of the treatment plan, care coordination, individual therapy, group therapy and counseling
G2087	Office-based treatment for OUD; At least 60 minutes in a subsequent calendar month, which could include care coordination, individual therapy, group therapy and counseling
G2088	Office-based treatment for OUD; Each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)

OUD screening is a requirement of the Medicare Initial Preventive Physical Exam (HCPCS G0402) Initial Medicare Annual Wellness Visit (HCPCS G0438) and Subsequent Medicare Annual Wellness Visit (HCPCS G0439).

Table 8. Behavioral Health Integration Services

G0323	Care management services for behavioral health conditions; At least 20 minutes of clinical psychologist or clinical social worker time, per calendar month
99484	Care management services for behavioral health conditions; At least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month
99492	Initial psychiatric collaborative care management; First 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant and directed by a treating physician or other qualified health care professional
99493	Follow-up psychiatric collaborative care management; First 60 minutes
99494	Initial or subsequent psychiatric collaborative care management; Each additional 30 minutes in a calendar month; List separately from the code for the primary procedure
G2214	Initial or subsequent psychiatric collaborative care management; First 30 minutes in a month of behavioral health care activities, in consultation with a psychiatric consultant and directed by a treating physician or other qualified health care professional

Table 9. Clinician-administered Medications

H0033	Non-covered by Medicare	Oral medication administration, direct observation
96372		Therapeutic, prophylactic or diagnostic injection (subcutaneous or intramuscular)
Q9991 (Sublicade)	Clinic-supplied medication (non-pharmacy); Excluded from physician fee schedule	Injection, buprenorphine extended release (Sublocade), less than or equal to 100 mg
Q9992 (Sublicade)	Clinic-supplied medication (non-pharmacy); Excluded from physician fee schedule	Injection, buprenorphine extended release (Sublocade), greater than 100 mg
J2315 (Naltrexone implant)	Clinic-supplied medication (non-pharmacy)	Naltrexone, injection, 1 mg
J0577 (Brixadi)	Clinic-supplied medication (non-pharmacy); Excluded from physician fee schedule	Buprenorphine extended-release, injection, less than or equal to seven days of treatment
J0578 (Brixadi)	Clinic-supplied medication (non-pharmacy); Excluded from physician fee schedule	Buprenorphine extended-release, injection, greater than seven days and up to 28 days of treatment
J0572 (Suboxone)	Clinic-supplied medication (non-pharmacy)	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine
J0573 (Suboxone)	Clinic-supplied medication (non-pharmacy)	Buprenorphine/naloxone, oral, greater than 3 mg but less than or equal to 6 mg buprenorphine
J0574 (Suboxone)	Clinic-supplied medication (non-pharmacy)	Buprenorphine/naloxone, oral, greater than 6 mg but less than or equal to 10 mg buprenorphine
J0575 (Suboxone)	Clinic-supplied medication (non-pharmacy)	Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine

Table 10. Medicare-enrolled Opioid Treatment Programs

G2067	Medication-assisted treatment, methadone; Weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing, if performed
G2068	MAT, buprenorphine (oral); Weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing, if performed
G2069	MAT, buprenorphine (injectable); Administered on a monthly basis; Bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing, if performed
G2073	MAT, naltrexone; Weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing, if performed
G2074	MAT; Weekly bundle not including the drug, including substance use counseling, individual and group therapy and toxicology testing, if performed
G2075	MAT, medication not otherwise specified; Weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing, if performed
G0533	MAT, buprenorphine (injectable); Weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing, if performed

Table 11. Opioid Treatment Program Intensity Add-on Codes

G2076*	Intake activities, including initial medical examination that is conducted by an appropriately licensed practitioner and preparation of a care plan, which may be informed by the administration of a standardized, evidence-based social determinants of health risk assessment to identify unmet health-related social needs, and that includes the patient's goals and mutually agreed-upon actions for the patient to meet those goals, including harm reduction interventions; the patient's needs and goals in the areas of education, vocational training and employment; and the medical and psychiatric, psychosocial, economic, legal, housing and other recovery support services that a patient needs and wishes to pursue, conducted by an appropriately licensed/credentialed personnel; List separately in addition to each primary code
G2077*	Periodic assessment; Assessing periodically by an OTP practitioner and includes a review of MOUD dosing, treatment response, other SUD treatment needs, responses and patient-identified goals and other relevant physical and psychiatric treatment needs and goals; Assessment may be informed by administration of a standardized, evidence-based social determinants of health risk assessment to identify unmet health-related social needs, or the need and interest for harm reduction interventions and recovery support services; List separately in addition to each primary code
G2078	Take-home supply of methadone; Up to seven additional day supply; List separately in addition to code for primary procedure
G2079	Take-home supply of buprenorphine (oral); Up to seven additional day supply; List separately in addition to code for primary procedure
G2080*	Each additional 30 minutes of counseling or group or individual therapy in a week of MAT; List separately in addition to code for primary procedure
G2215	Take-home supply of nasal naloxone; List separately in addition to code for primary procedure
G2216	Take-home supply of injectable naloxone; List separately in addition to code for primary procedure
G1028	Take-home supply of nasal naloxone; Two-pack of 8 mg per 0.1 mL nasal spray; List separately in addition to code for primary procedure
G0137	Intensive outpatient services; Minimum of nine services over a seven-contiguous day period, which can include individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law); Occupational therapy requiring the skills of a qualified occupational therapist; Services of social workers, trained psychiatric nurses and other staff trained to work with psychiatric patients; Drugs and biologicals furnished for therapeutic purposes, excluding opioid agonist and antagonist medications that are FDA-approved for use in treatment of OUD or opioid antagonist medications for the emergency treatment of known or suspected opioid overdose; Individualized activity therapies that are not primarily recreational or diversionary; Family counseling (the primary purpose of which is treatment of the individual's condition); Patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); Diagnostic services (not including toxicology testing); List separately in addition to code for primary procedure
G0532	Take-home supply of nasal nalmefene hydrochloride; One carton of two, 2.7 mg per 0.1 mL nasal sprays; List separately in addition to each primary code
G0534	Coordinated care and/or referral services, such as adequate and accessible community resources to address unmet health-related social needs, including harm reduction interventions and recovery support services a patient needs and wishes to pursue, which significantly limit the ability to diagnose or treat an OUD; Each additional 30 minutes of services; List separately in addition to each primary code
G0535	Patient navigational services, provided directly or by referral, including helping the patient to navigate health systems and identify care providers and supportive services, to build patient self-advocacy and communication skills with care providers, and to promote patient-driven action plans and goals; Each additional 30 minutes of services; List separately in addition to each primary code
G0536	Peer recovery support services, provided directly or by referral, including leveraging the knowledge of the condition or lived experience to provide support, mentorship or inspiration to meet OUD treatment and recovery goals; Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes; Developing and proposing strategies to help meet person-centered treatment goals; Assisting the patient in locating or navigating recovery support services; Each additional 30 minutes of services; List separately in addition to each primary code

**The service may be provided via two-way, interactive, audio-video or audio-only technology when audio-video technology isn't available. Append modifier 95 for counseling and therapy provided via audio-video technology or modifier 93 for counseling and therapy provided using audio-only technology. Use place of service 58 on all claims for OTP services, including those provided via two-way, interactive, audio-video or audio-only technology. One week is defined as seven days in a row. All claims submitted under the OTP benefit must include an OUD diagnosis. Applicable diagnoses include ICD-10-CM codes in the F11 range for "disorders related to or resulting from abuse or misuse of opioids."*

Table 12. ICD-10 Codes for Opioid Use, Abuse and Dependence

ICD-10	Description	Guidance
Opioid abuse (F11.1X) – OUD, mild		
F11.10	Opioid abuse, uncomplicated	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.11	Opioid abuse, in remission	
F11.120	Opioid abuse with intoxication, uncomplicated	
F11.121	Opioid abuse with intoxication, delirium	
F11.122	Opioid abuse with intoxication, with perceptual disturbance	
F11.13	Opioid abuse with withdrawal	
F11.14	Opioid abuse with opioid-induced mood disorder	
F11.150	Opioid abuse with opioid-induced psychotic disorder, with delusions	
F11.151	Opioid abuse with opioid-induced psychotic disorder, with hallucinations	
F11.181	Opioid abuse with opioid-induced sexual dysfunction	
F11.182	Opioid abuse with opioid-induced sleep disorder	
F11.188	Opioid abuse with other opioid-induced disorder	
F11.19	Opioid abuse with unspecified opioid-induced disorder	
Opioid dependence (F11.2X) – OUD, moderate or severe		
F11.20	Opioid dependence, uncomplicated	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.21	Opioid dependence, in remission	
F11.220	Opioid dependence with intoxication, uncomplicated	
F11.221	Opioid dependence with intoxication, delirium	
F11.222	Opioid dependence with intoxication, with perceptual disturbance	
F11.23	Opioid dependence with withdrawal	
F11.24	Opioid dependence with opioid-induced mood disorder	
F11.250	Opioid dependence with opioid-induced psychotic disorder, with delusions	
F11.251	Opioid dependence with opioid-induced psychotic disorder, with hallucinations	
F11.281	Opioid dependence with opioid-induced sexual dysfunction	
F11.282	Opioid dependence with opioid-induced sleep disorder	
F11.288	Opioid dependence with other opioid-induced disorder	
F11.29	Opioid dependence with unspecified opioid-induced disorder	
Opioid Use (F11.9X) – Opioid use unspecified (can be used to avoid stigmatizing language in EHR)		
F11.90	Opioid use, unspecified, uncomplicated	F11.9X cannot be billed with F11.1-F11.19 or F11.2-F11.29
F11.91	Opioid use, unspecified, in remission	
F11.920	Opioid use, unspecified with intoxication, uncomplicated	
F11.921	Opioid use, unspecified with intoxication delirium	
F11.922	Opioid use, unspecified with intoxication, with perceptual disturbance	
F11.93	Opioid use, unspecified, with withdrawal	
F11.94	Opioid use, unspecified, with opioid-induced mood disorder	
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder, with delusions	
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder, with hallucinations	
F11.981	Opioid use, unspecified with opioid-induced sexual dysfuncion	
F11.982	Opioid use, unspecified with opioid-induced sleep disorder	
F11.988	Opioid use, unspecified with other opioid-induced disorder	
F11.99	Opioid use, unspecified, with unspecified opioid-induced disorder	

Table 13. Narcotics: Poisoning, Adverse Effect and Underdosing

ICD-10	Description	Guidance
Opium		
T40.0X1A	Poisoning by opium, accidental (unintentional), initial encounter	
T40.0X1D	Poisoning by opium, accidental (unintentional), subsequent encounter	
T40.0X1S	Poisoning by opium, accidental (unintentional), sequela	
T40.0X2A	Poisoning by opium, intentional self-harm, initial encounter	
T40.0X2D	Poisoning by opium, intentional self-harm, subsequent encounter	
T40.0X2S	Poisoning by opium, intentional self-harm, sequela	
T40.0X3A	Poisoning by opium, assault, initial encounter	
T40.0X3D	Poisoning by opium, assault, subsequent encounter	
T40.0X3S	Poisoning by opium, assault, sequela	
T40.0X4A	Poisoning by opium, undetermined, initial encounter	
T40.0X4D	Poisoning by opium, undetermined, subsequent encounter	
T40.0X4S	Poisoning by opium, undetermined, sequela	
T40.0X5A	Adverse effect of opium, initial encounter	
T40.0X5D	Adverse effect of opium, subsequent encounter	
T40.0X5S	Adverse effect of opium, sequela	
T40.0X6A	Underdosing of opium, initial encounter	
T40.0X6D	Underdosing of opium, subsequent encounter	
T40.0X6S	Underdosing of opium, sequela	
Heroin		
T40.1X1A	Poisoning by heroin, accidental (unintentional), initial encounter	
T40.1X1D	Poisoning by heroin, accidental (unintentional), subsequent encounter	
T40.1X1S	Poisoning by heroin, accidental (unintentional), sequela	
T4 0.1X2A	Poisoning by heroin, intentional self-harm, initial encounter	
T40.1X2D	Poisoning by heroin, intentional self-harm, subsequent encounter	
T40.1X2S	Poisoning by heroin, intentional self-harm, sequela	
T40.1X3A	Poisoning by heroin, assault, initial encounter	
T40.1X3D	Poisoning by heroin, assault, subsequent encounter	
T40.1X3S	Poisoning by heroin, assault, sequela	
T40.1X4A	Poisoning by heroin, undetermined, initial encounter	
T40.1X4D	Poisoning by heroin, undetermined, subsequent encounter	
T40.1X4S	Poisoning by heroin, undetermined, sequela	
Other Opioids		
T40.2X1A	Poisoning by other opioids, accidental (unintentional), initial encounter	
T40.2X1D	Poisoning by other opioids, accidental (unintentional), subsequent encounter	
T40.2X1S	Poisoning by other opioids, accidental (unintentional), sequela	
T40.2X2A	Poisoning by other opioids, intentional self-harm, initial encounter	
T40.2X2D	Poisoning by other opioids, intentional self-harm, subsequent encounter	
T40.2X2S	Poisoning by other opioids, intentional self-harm, sequela	
T40.2X3A	Poisoning by other opioids, assault, initial encounter	
T40.2X3D	Poisoning by other opioids, assault, subsequent encounter	
T40.2X3S	Poisoning by other opioids, assault, sequela	
T40.2X4A	Poisoning by other opioids, undetermined, initial encounter	
T40.2X4D	Poisoning by other opioids, undetermined, subsequent encounter	
T40.2X4S	Poisoning by other opioids, undetermined, sequela	
T40.2X5A	Adverse effect of other opioids, initial encounter	
T40.2X5D	Adverse effect of other opioids, subsequent encounter	

Other Opioids, continued		
T40.2X5S	Adverse effect of other opioids, sequela	
T40.2X6A	Underdosing of other opioids, initial encounter	
T40.2X6D	Underdosing of other opioids, subsequent encounter	
T40.2X6S	Underdosing of other opioids, sequela	
Methadone		
T40.3X1A	Poisoning by methadone, accidental (unintentional), initial encounter	
T40.3X1D	Poisoning by methadone, accidental (unintentional), subsequent encounter	
T40.3X1S	Poisoning by methadone, accidental (unintentional), sequela	
T40.3X2A	Poisoning by methadone, intentional self-harm, initial encounter	
T40.3X2D	Poisoning by methadone, intentional self-harm, subsequent encounter	
T40.3X2S	Poisoning by methadone, intentional self-harm, sequela	
T40.3X3A	Poisoning by methadone, assault, initial encounter	
T40.3X3D	Poisoning by methadone, assault, subsequent encounter	
T40.3X3S	Poisoning by methadone, assault, sequela	
T40.3X4A	Poisoning by methadone, undetermined, initial encounter	
T40.3X4D	Poisoning by methadone, undetermined, subsequent encounter	
T40.3X4S	Poisoning by methadone, undetermined sequela	
T40.3X5A	Adverse effect of methadone, initial encounter	
T40.3X5D	Adverse effect of methadone, subsequent encounter	
T40.3X5S	Adverse effect of methadone, sequela	
T40.3X6A	Underdosing of methadone, initial encounter	
T40.3X6D	Underdosing of methadone, subsequent encounter	
T40.3X6S	Underdosing of methadone, sequela	
Fentanyl		
T40.411A	Poisoning by fentanyl or fentanyl analogs, accidental (unintentional), initial encounter	
T40.411D	Poisoning by fentanyl or fentanyl analogs, accidental (unintentional), subsequent encounter	
T40.411S	Poisoning by fentanyl or fentanyl analogs, accidental (unintentional), sequela	
T40.412A	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, initial encounter	
T40.412D	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, subsequent encounter	
T40.412S	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, sequela	
T40.413A	Poisoning by fentanyl or fentanyl analogs, assault, initial encounter	
T40.413D	Poisoning by fentanyl or fentanyl analogs, assault, subsequent encounter	
T40.413S	Poisoning by fentanyl or fentanyl analogs, assault, sequela	
T40.414A	Poisoning by fentanyl or fentanyl analogs, undetermined, initial encounter	
T40.414D	Poisoning by fentanyl or fentanyl analogs, undetermined, subsequent encounter	
T40.414S	Poisoning by fentanyl or fentanyl analogs, undetermined, sequela	
T40.415A	Adverse effect of fentanyl or fentanyl analogs, initial encounter	
T40.415D	Adverse effect of fentanyl or fentanyl analogs, subsequent encounter	
T40.415S	Adverse effect of fentanyl or fentanyl analogs, sequela	
T40.416A	Underdosing of fentanyl or fentanyl analogs, initial encounter	
T40.416D	Underdosing of fentanyl or fentanyl analogs, subsequent encounter	
T40.416S	Underdosing of fentanyl or fentanyl analogs, sequela	
Other Synthetic Narcotics		
T40.491A	Poisoning by other synthetic narcotics, accidental (unintentional), initial encounter	
T40.491D	Poisoning by other synthetic narcotics, accidental (unintentional), subsequent encounter	
T40.491S	Poisoning by other synthetic narcotics, accidental (unintentional), sequela	
T40.492A	Poisoning by other synthetic narcotics, intentional self-harm, initial encounter	

Other Synthetic Narcotics, continued		
T40.492D	Poisoning by other synthetic narcotics, intentional self-harm, subsequent encounter	
T40.492S	Poisoning by other synthetic narcotics, intentional self-harm, sequela	
T40.493A	Poisoning by other synthetic narcotics, assault, initial encounter	
T40.493D	Poisoning by other synthetic narcotics, assault, subsequent encounter	
T40.493S	Poisoning by other synthetic narcotics, sequela	
T40.494A	Poisoning by other synthetic narcotics, undetermined, initial encounter	
T40.494D	Poisoning by other synthetic narcotics, undetermined, subsequent encounter	
T40.494S	Poisoning by other synthetic narcotics, undetermined, sequela	
T40.495A	Adverse effect of other synthetic narcotics, initial encounter	
T40.495D	Adverse effect of other synthetic narcotics, subsequent encounter	
T40.495S	Adverse effect of other synthetic narcotics, sequela	
T40.496A	Underdosing of other synthetic narcotics, initial encounter	
T40.496D	Underdosing of other synthetic narcotics, subsequent encounter	
T40.496S	Underdosing of other synthetic narcotics, sequela	
Unspecified Narcotics		
T40.601A	Poisoning by unspecified narcotics, accidental (unintentional), initial encounter	
T40.601D	Poisoning by unspecified narcotics, accidental (unintentional), subsequent encounter	
T40.601S	Poisoning by unspecified narcotics, accidental (unintentional), sequela	
T40.602A	Poisoning by unspecified narcotics, intentional self-harm, initial encounter	
T40.602D	Poisoning by unspecified narcotics, intentional self-harm, subsequent encounter	
T40.602S	Poisoning by unspecified narcotics, intentional self-harm, sequela	
T40.603A	Poisoning by unspecified narcotics, assault, initial encounter	
T40.603D	Poisoning by unspecified narcotics, assault, subsequent encounter	
T40.603S	Poisoning by unspecified narcotics, assault, sequela	
T40.604A	Poisoning by unspecified narcotics, undetermined, initial encounter	
T40.604D	Poisoning by unspecified narcotics, undetermined, subsequent encounter	
T40.604S	Poisoning by unspecified narcotics, undetermined, sequela	
T40.605A	Adverse effect of unspecified narcotics, initial encounter	
T40.605D	Adverse effect of unspecified narcotics, subsequent encounter	
T40.605S	Adverse effect of unspecified narcotics, sequela	
T40.606A	Underdosing of unspecified narcotics, initial encounter	
T40.606D	Underdosing of unspecified narcotics, subsequent encounter	
T40.606S	Underdosing of unspecified narcotics, sequela	
Other Narcotics		
T40.691A	Poisoning by other narcotics, accidental (unintentional), initial encounter	
T40.691D	Poisoning by other narcotics, accidental (unintentional), subsequent encounter	
T40.691S	Poisoning by other narcotics, accidental (unintentional), sequela	
T40.692A	Poisoning by other narcotics, intentional self-harm, initial encounter	
T40.692D	Poisoning by other narcotics, intentional self-harm, subsequent encounter	
T40.692S	Poisoning by other narcotics, intentional self-harm, sequela	
T40.693A	Poisoning by other narcotics, assault, initial encounter	
T40.693D	Poisoning by other narcotics, assault, subsequent encounter	
T40.693S	Poisoning by other narcotics, assault, sequela	
T40.694A	Poisoning by other narcotics, undetermined, initial encounter	
T40.694D	Poisoning by other narcotics, undetermined, subsequent encounter	
T40.694S	Poisoning by other narcotics, undetermined, sequela	
T40.695A	Adverse effect of other narcotics, initial encounter	

Other Narcotics, continued		
T40.695D	Adverse effect of other narcotics, subsequent encounter	
T40.695S	Adverse effect of other narcotics, sequela	
T40.696A	Underdosing of other narcotics, initial encounter	
T40.696D	Underdosing of other narcotics, subsequent encounter	
T40.696S	Underdosing of other narcotics, sequela	
Analeptics and Opioid Receptor Antagonists		
T50.7X1A	Poisoning by analeptics and opioid receptor antagonists, accidental (unintentional), initial encounter	
T50.7X1D	Poisoning by analeptics and opioid receptor antagonists, accidental (unintentional), subsequent encounter	
T50.7X1S	Poisoning by analeptics and opioid receptor antagonists, accidental (unintentional), sequela	
T50.7X2A	Poisoning by analeptics and opioid receptor antagonists, intentional self-harm, initial encounter	
T50.7X2D	Poisoning by analeptics and opioid receptor antagonists, intentional self-harm, subsequent encounter	
T50.7X2S	Poisoning by analeptics and opioid receptor antagonists, intentional self-harm, sequela	
T50.7X3A	Poisoning by analeptics and opioid receptor antagonists, assault, initial encounter	
T50.7X3D	Poisoning by analeptics and opioid receptor antagonists, assault, subsequent encounter	
T50.7X3S	Poisoning by analeptics and opioid receptor antagonists, assault, sequela	
T50.7X4A	Poisoning by analeptics and opioid receptor antagonists, undetermined, initial encounter	
T50.7X4D	Poisoning by analeptics and opioid receptor antagonists, undetermined, subsequent encounter	
T50.7X4S	Poisoning by analeptics and opioid receptor antagonists, undetermined, sequela	
T50.7X5A	Adverse effect of analeptics and opioid receptor antagonists, initial encounter	
T50.7X5D	Adverse effect of analeptics and opioid receptor antagonists, subsequent encounter	
T50.7X5S	Adverse effect of analeptics and opioid receptor antagonists, sequela	
T50.7X6A	Underdosing of analeptics and opioid receptor antagonists, initial encounter	
T50.7X6D	Underdosing of analeptics and opioid receptor antagonists, subsequent encounter	
T50.7X6S	Underdosing of analeptics and opioid receptor antagonists, sequela	
Counseling		
Z71.51	Drug abuse counseling and surveillance of drug abuser	
Z71.89	Other specified counseling	Z71.89 is not a valid primary diagnosis

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