Treating Opioid Use Disorder as a Chronic Condition

A Practice Manual for Family Physicians

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AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

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Introduction

In 2016, an estimated 11.8 million Americans 12 years or older misused opioids, with an estimated 2.1 million having an opioid use disorder (OUD).[1] This includes 1.8 million individuals with a prescription pain reliever use disorder and 0.6 million with a heroin use disorder.[1] Some individuals have dual disorders. Of those 2.1 million individuals with an OUD, only 17.5% were able to access treatment that year,[2] leaving a significant gap for individuals in need of treatment.

The American Academy of Family Physician (AAFP) position paper, Chronic Pain Management and Opioid Misuse: A Public Health Concern, supports integrated chronic care management with medication-assisted treatment (MAT) as part of a comprehensive primary care practice to address opioid dependence.[3]

MAT for OUDs has been shown to significantly decrease mortality,[4] but only a fraction of eligible patients get treatment.[5] Evidence-based treatment, such as buprenorphine, methadone, and naloxone, allows patients an opportunity to enter full recovery.[6]

OPIOID USE DISORDER (OUD)

is a chronic, relapsing condition. Treatment of OUD falls within the scope of practice of family physicians.

Family physicians and other primary care clinicians are in an ideal position to integrate early substance use disorder (SUD) prevention services; utilize screening, brief intervention, and referral to treatment (SBIRT) for OUDs; and implement medication use for opioid use disorder (MOUD).[7,8] By doing so, physicians and other clinicians play a critical role in the prevention and treatment of OUD.

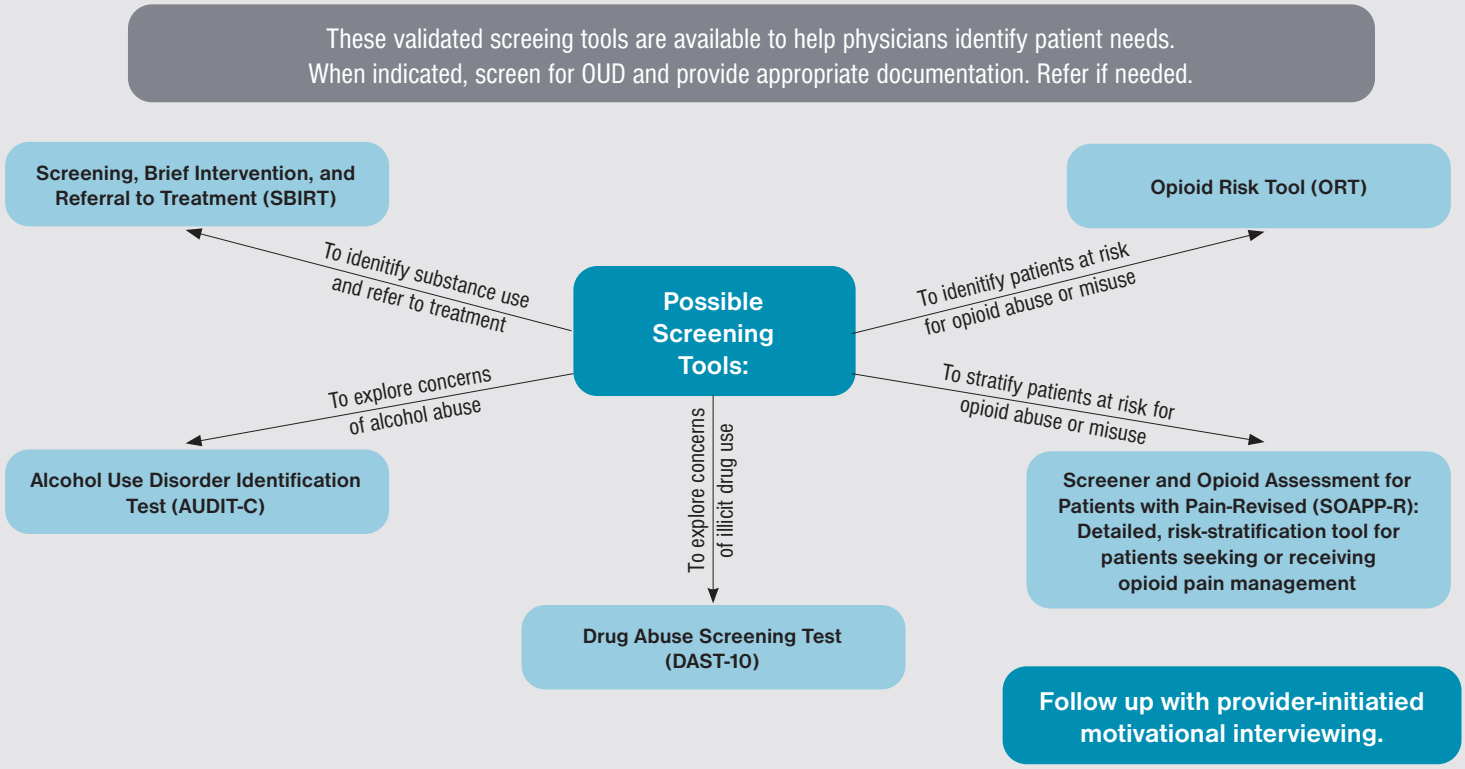
This practice manual provides guidance for incorporating opioid screening and brief intervention (SBI), as well as evidence-based treatment into primary care practice.

Screening for OUD

Many professional organizations, including the AAFP, American College of Obstetricians and Gynecologists (ACOG), American Academy of Addiction Psychiatry (AAAP), American Society of Addiction Medicine (ASAM), and the U.S. Preventive Services Task Force (USPSTF), recognize the importance of selective screening, treatment, and behavioral counseling interventions to reduce opioid misuse and abuse. Though there have been some differences in the strength of recommendations, ***"screening programs should only be implemented if services for accurate diagnosis, effective treatment, and psychosocial supports can be offered or referred."***[9]

After identifying patients who are recommended for screening, standardize your process for screening, brief intervention, and treatment or referral. Most electronic health records (EHRs) 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 help to easily identify patients with an OUD. The SAMSHA guide, Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR), has details on numerous screening tools.[10]

The graphic below contains approaches and validated screening tools used to identify patients in need of further treatment.[11-16] Begin with the SBIRT and utilize other options as needed for the patient and situation (e.g., Opioid Risk Tool [ORT] or Screener and Opioid Assessment for Patients with Pain-Revised [SOAPP-Revised] for patients in need of pain management; Drug Abuse Screening Test [DAST-10] for patients with possible illicit drug use).



Identify and Overcome Barriers to Screening

When screening patients for OUD, there might be multiple challenges. For many physicians, common barriers to implement and promote SBI and OUD treatment include:

- Stigma and bias about OUD
- Lack of waivered clinicians to treat OUD
- Lack of knowledge and understanding of OUD diagnostic criteria, assessment, and treatment options

Words Matter

Treating patients with respect reinforces the physician-patient relationship and empowers the patient to share in creating and successfully utilizing treatment. Recognize that the words physicians and other clinicians use matter, and terminology is ever-changing. For a recent complete list of terms to use when talking with patients about OUD, TIP 63: Medications for Opioid Use Disorder has key terms in each section.[17] Below are a few terms with previous language and language that is now recommended,[18] along with sample conversation starters using recommended language.

No longer recommended language	Recommended language
Addict	Person with disorder/person who uses drugs
Clean urine/dirty urine	Urine as expected/urine as unexpected
Detoxification	Withdrawal management
Addicted baby	Neonate with in utero exposure
Relapse	Return to use

Sample Conversation Starters

"Your answers on this **screening test** show that the use of opiates and other substances may be affecting your daily life. Let's discuss that."

"This **urine drug screen** has **unexpected results** and shows several non-prescribed drugs. I am concerned that these could be dangerous to your health. Can you tell me more about what has been going on recently?"

"In order to avoid exposure of a newborn, it is important that if you are **using drugs** or substances, you have access to a method of birth control or medication-assisted treatment, as needed."

"Many **people who use drugs** discover that group meetings with others who have a similar experience can be really helpful to their recovery."

"The first step to initiate long-acting naloxone is **withdrawal management**. After withdrawal is complete, the injection can be administered."

"Once you are stable on buprenorphine, it is important to make a plan to prevent a **return to use** of illicit opiates."

More specific examples of interview questions and responses are available at TIP 34: Brief Interventions and Brief Therapies for Substance Abuse.[19]

Addressing Stigma and Bias

Patients with an OUD are a marginalized community that experience stigma and bias. Physicians and their care teams need to be mindful of the social and structural determinants that impact health and well-being, as well as recognize implicit bias towards patients with an OUD. Implicit bias is defined as "the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner."[20] The AAFP has more resources and trainings on implicit bias as part of its EveryONE Project.[21]

Physicians and other clinicians should discuss OUD as a chronic relapsing disease, such as diabetes, hypertension, and asthma. In the approach to long-term OUD care, continue treatment for as long as it benefits the patient.[22]

Equity Considerations

Physicians and other clinicians must address the public health issue of OUD with consideration of historical health inequity, as it has roots in the social and structural determinants of health. Marginalized populations have been and continue to be negatively affected by SUD, as well as by a lack of access to appropriate evidence-based treatment.[23] Significant health disparities in opioid prescription and administration exist for patients in racial and ethnic minority groups and LGBTQ+ patients.[24-25] In facilities where buprenorphine is available, barriers exist, such as lack of treatment for outpatients, lack of new patient capacity, referral requirements, waitlists, and lack of insurance acceptance.[26]

Physicians and other clinicians must attempt to reduce these inequities through accountable practices and systemic change. These include recognizing the role social determinants of health (SDoH) play in health disparities and addressing them with every patient; gaining the awareness of implicit bias in the care setting; and developing anti-oppression curriculum in medical schools and in continuing medical education.[27] Engaging with community and non-health organizations can also help foster health-promoting neighborhoods and allow physicians and other clinicians to serve as advocates for the health and wellness of their patients.[28]

Finally, physicians and other clinicians must advocate 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.[28] One tangible policy change family physicians can help advocate for in their communities is to ensure that pharmacies and other referral sites offer low-cost treatment options for people with an OUD who are uninsured. Be mindful that these sites are also accessible by public transportation.

Diagnostic Criteria and Assessment

The Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 criteria contains specific criteria and classification of OUD (mild, moderate, or severe).[29]

Assessment

The DSM-5 includes elements of tolerance, dependence, loss of control, and personal consequences of opioid use. Properly assessing patients with an OUD entails:[17]

- Documenting that the patient meets criteria for OUD and 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, along with how, when, and where the conditions will be addressed
- Evaluating the patient's level of 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 (STIs), HIV, hepatitis B (Hep B), and Hep C

Treating OUD

Medications for OUD

There are different options for treating OUD. Consider how treatment will work best with your clinic resources and patient population. Evidence-based treatment includes MAT. Medications used for OUD are methadone, buprenorphine, naltrexone, and naloxone. Methadone and buprenorphine reduce or suppress opioid cravings and withdrawal. Buprenorphine can also blunt the effects of other opioids. Naltrexone works to block euphoric and sedative effects of the abused drug and blocks neural addiction pathways. Naloxone is used to reverse opioid overdose.[6] This section explains these medications, their uses, and safety precautions. The table at the end of this section provides an overview of methadone, buprenorphine, and naltrexone.

Any medication used in MAT should be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.[17]

Methadone

Methadone is a Schedule II controlled medication. It is a daily dosed, long-acting, full opioid agonist approved by the Food and Drug Administration (FDA) for the treatment of OUD and chronic pain.[30] It reduces opioid withdrawal symptoms and cravings. When taken as prescribed, methadone is a safe and effective form of MAT which helps individuals dependent on opioids to achieve sustained sobriety.[30]

Methadone Potential Misuse

As a highly potent opioid, there is a potential risk of overdose of methadone if not taken as prescribed. Like other opioids, methadone can cause nausea, vomiting, constipation, and slowed breathing. To mitigate these risks, methadone must be taken under the supervision of a clinician and can only be dispensed by a Substance Abuse and Mental Health Services Administration (SAMHSA)-certified opioid treatment program (OTP).[30]

According to the ASAM National Practice Guideline, the recommended initial dose for methadone ranges from 10-30 milligrams (mg), with reassessment in 3-4 hours. A second dose should not exceed 10 mg on the first day if withdrawal symptoms are persisting. For daily use, dosage for methadone ranges from 60-120 mg. The dosage will depend on the patient, with some responding better to lower doses, while others may need higher doses. Increase dosage in 5-10 mg increments, with increases no more frequent than every seven days (depending on the patient's clinical response). This is necessary to avoid oversedation, toxicity, or even iatrogenic overdose deaths.[31]

Buprenorphine

As an opioid partial agonist, buprenorphine helps control cravings and prevents symptoms of opiate withdrawal while partially blocking the action of opiate agonists, such as heroin, prescription opiates, and synthetic opiates. High doses of buprenorphine do not cause higher levels of respiratory depression, making this medication significantly safer than full agonist opioids. Buprenorphine can also be used for treatment of pain in different formulations.[32]

Buprenorphine Potential Misuse

There is a potential for misuse of buprenorphine due to its opioid effects. Coformulation of buprenorphine with naloxone helps decrease diversion and misuse of the two medications in combination. Buprenorphine is well absorbed via the buccal or sublingual route, whereas naloxone is not. By crushing and injecting the coformulated sublingual tablets, the naloxone is absorbed and can block the euphoric effect of buprenorphine and cause withdrawal symptoms.[33] Buprenorphine products are sometimes diverted. A recent study showed the majority of diversions are used to prevent withdrawal symptoms (79%), maintain abstinence (67%), or to self-wean off drugs (53%).[34]

Buprenorphine Safety

When taking buprenorphine, physicians should be aware of other medications the patient is taking. Strongly advise them to avoid common drugs of abuse, such as alcohol, sedatives, tranquilizers, or other drugs that cause respiratory depression. Mixing other depressants with buprenorphine can lead to overdose or death. As buprenorphine is hepatically metabolized, monitor any liver-related health issues the patient may have.[32,33]

Naltrexone

Any physician licensed to prescribe medications can prescribe naltrexone. The long-acting injectable formulation requires a risk evaluation and mitigation strategy (REMS) to ensure that the benefits of the drug outweigh its risks.[35] Naltrexone can be used to treat OUD and alcohol use disorder (AUD). The oral formulation is mainly used to treat AUD, and the injectable is for either AUD or OUD. Warn patients to abstain from all opioids and alcohol at least 7-10 days before starting injectable naltrexone in order to lower the chance of acute withdrawal.[35] Once initiated, success rates for injectable naltrexone are similar to oral buprenorphine, but there is a high dropout rate during the initiation period.[36]

How Naltrexone Works

Naltrexone acts as a complete antagonist at the opioid receptor, blocking the effect of other opiates and reducing cravings. Abuse and diversion potential with naltrexone is limited, if any. If a patient has a return to use, naltrexone prevents all the effects of the illicit opioid.[37]

Patients discontinuing the use of naltrexone experience a reduced tolerance to opioids. They may not be aware of their sensitivity to the same, or even lower doses of opioids they had previously taken. If patients return to use or relapse, the dosage of an opioid previously used may have life-threatening respiratory depression or circulatory collapse responses.[37]

Naloxone

Another FDA-approved medication in the treatment of OUD is naloxone. It can be administered through an intranasal spray, intramuscular, subcutaneous, or by intravenous injection to help reverse an opioid overdose.[38] According to the World Health Organization, naloxone is considered an essential medication to a functioning health care system.[39]

> ***"The AAFP supports efforts to promote naloxone kits for lay public usage as part of overdose prevention programs and the implementation of legislation which protects any individuals who administer naloxone from prosecution for practicing medicine without a license. The AAFP supports policies which promote the provision of naloxone to patients using opioids or other individuals in close contact with those patients, including personnel at safe injection sites. The AAFP supports the implementation of programs which allow first responders and non-medical personnel to possess and administer naloxone in emergency situations.***
>
> ***The AAFP promotes the passage of 911 Good Samaritan Immunity laws to exempt the lay public from prosecution when contacting emergency medical services (EMS) to report overdoses and physicians from treating an overdose at a safe injection site."***[40]

Patients who are Pregnant and/or Breastfeeding

Methadone or buprenorphine monoproduct (without naloxone) is the standard of care for patients who are pregnant and have an OUD. Consultation with an expert in this area is recommended before initiating or altering MAT in a patient who is pregnant or breastfeeding.[32]

Comparing Medications for OUD

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

Comparison of Methadone, Buprenorphine, and Naltrexone for OUDs[41,42]

	Methadone (Schedule II)	Buprenorphine (Schedule III)	Naltrexone
FDA-approved formulations with recommended dose	**Tablet:** • 5 mg • 10 mg **Dispersible tablet:** • 40 mg **Oral solution:** • 5 mg/5 mL • 10 mg/5 mL	**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	**Naltrexone *(Depade® and ReVia®)* oral tablet:** • 50 mg **Naltrexone *(Vivitrol®)* XR depo:** • 380 mg

Comparison of Methadone, Buprenorphine, and Naltrexone for OUDs[41,42], continued			
	Methadone (Schedule II)	**Buprenorphine (Schedule III)**	**Naltrexone (IM)**
Pharmacology	Full agonist	Partial agonist	Full antagonist
Dosing	Daily (but duration often longer)	Daily	Every four weeks
Setting	Specialty licensed opioid treatment program (OTP)	Office-based or OTP; requires "X" waiver	Any medical setting; requires injection
Induction	No time restriction; start low, go slow	Mild to moderate withdrawal: >8-12 hours after last opioid	>7 days after last opioid
Adherence	Intrinsically reinforcing	Intrinsically reinforcing	Long acting
Craving reduction	+++	++	+
Effectiveness	• Most studied compared with buprenorphine and naltrexone • Treatment retention superior to low-dose buprenorphine; equivalent to high-dose buprenorphine • Associated with decreases in mortality (all-cause mortality is three times higher when methadone is stopped), opioid use, HIV transmission, and risky behaviors	• At doses >16 mg, treatment retention equivalent to methadone and higher than naltrexone • All-cause mortality reduced by 50% • Much more effective than placebo at treatment retention (risk ration = 1.82) and decreased illicit opioid-positive urine samples	• Least well studied compared with methadone and buprenorphine • Oral form is not FDA approved for MAT • Monthly intramuscular form has better treatment retention than nonpharmacologic therapies, but the lowest treatment retention of the three medication options • Patients who successfully complete induction phase may have treatment retention similar to those on buprenorphine • Has not been shown to decrease all-cause or drug-specific mortality
Adverse effects	• Sedation may occur • Constipation • Hypogonadism • Prolonged QT interval • Drug-drug interactions • Overdose is possible at high dose or in combination with other drugs	• Sedation rare • Headache • Nausea • Constipation • Insomnia/hypomania in predisposed patients	• Injection site reactions • Headache • Depression • Insomnia • Increased alanine transaminase • Increased creatine phosphokinase • Difficult pain management • Decreased tolerance and may therefore increase risk of overdose if return to use
Contraindications	• Hypersensitivity • 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 • Substance use disorder treatment program • Any outpatient setting	• Primary care clinic • Psychiatric clinic • Prenatal clinic • Substance use disorder treatment program • OTP • Any outpatient setting

Comparison of Methadone, Buprenorphine, and Naltrexone for OUDs[41,42] continued			
	Methadone (Schedule II)	**Buprenorphine (Schedule III)**	**Naltrexone**
Patient considerations	• No withdrawal required for treatment initiation • Initially must be seen daily	• Mild withdrawal required for treatment initiation, usually 8-48 hours of abstinence • May need to be seen one to two times per week initially, can typically be spaced to monthly visits	• Must completely withdraw from opioids before treatment initiation, usually 7-14 days of abstinence • May be seen monthly for injections
Regulatory considerations	Must be administered in an OTP or be dispensed to those who are inpatient hospitalized for another diagnosis	Prescriber must have a Drug Enforcement Administration (DEA) waiver or be providing addiction treatment incidental to hospitalization for another diagnosis	• No restrictions on prescribing • Must be stored in clinic refrigerator and administered by trained staff
Diversion/misuse	Diversion and misuse are possible	Diversion and misuse are possible	No risk
Patient who are pregnant	Treatment with methadone should be initiated as early as possible during pregnancy.	Buprenorphine monoproduct is a reasonable and recommended alternative to methadone.	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, patients should be seen at least weekly. If they are actively using drugs or have barriers to medication complicance, seeing the patient every two to three days may be appropriate. As the patient shows urine drug screens consistent with recovery and are engaged in counseling, and/or a recovery community, the time between encounters can be increased.[43] Additional resources about urine drug screening can be found in the AAFP Chronic Pain Management Toolkit.[44]

Urine drug screens are an important tool in MAT. Other than the Clinical Opiate Withdrawal Score (COWS)[45] and physical withdrawal, drug testing is the only objective measure available in the addiction field.[43] Patients often view drug testing as punitive. However, physicians should use results to start a conversation with a patient and guide treatment.

Return to Use

When a patient has an unexpected urine drug screen result or discusses a return to use, it is important to communicate to them that what they are experiencing is a chronic illness and that return to use commonly occurs. Follow these steps to help patients when they return to use:

- Emphasize that the treatment team will continue to encourage their recovery. The return to use might just mean something may not be working right, and the support and/or treatment may need to be re-evaluated. The patient may need a higher level of care or to connect with community resources.
- Manage the patient's expectations for recovery and provide next steps for the patient's recovery goals.
- Ensure that the patient has naloxone and access to syringe service programs.

Behavioral Health Interventions

The ASAM Criteria guides intervention efforts about counseling and behavioral services for a patient with addiction and co-occurring conditions.[46] For patients who have recently experienced an overdose and have no psychosocial supports, inpatient services may be needed. If a patient declines inpatient services, day treatment programs or intensive outpatient programs might be helpful.

Patients with SUDs are more likely to have been exposed to traumatic events and to develop post-traumatic stress disorder (PTSD).[47] 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.

Intensive outpatient therapy may include individual or group visits. Groups typically meet three times a week. Depending on the social supports available to the patient, this can be a great option for patients to have time in therapy and treatment, and to be away from using substances while not having to be in an inpatient setting.[48] Behavioral health integration can include remote collaboration with a psychiatrist or psychiatrist nurse practitioner. The clinician or staff member working under that physician can provide a 20-minute check in with a patient who has been diagnosed with a behavioral health condition.[49]

Preparing Your Practice

Becoming MAT Waivered

A common misconception associated with MAT is that it substitutes one drug for another. Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the brain. MAT programs provide a safe and controlled level of medication to overcome the use of an abused opioid.[6]

Individuals may safely take medications used in MAT for months, years, or even a lifetime.[6] Plans to stop a medication should be done in a collaborative way with the patient and physician/treatment team. Shared decision making about medication selection and duration involves patients, physicians, and other health care workers, and will depend on the medication's effectiveness and adverse effects, as well as patient preference and availability.[50]

Physicians must be certified after completing the required Drug Addiction Treatment Act 2000 (DATA 2000) waiver training to provide MAT.[51] The SAMHSA's Division of Pharmacologic Therapies (DPT) makes required buprenorphine training available for physicians, including webinars, workshops, summits, publications, and research.

There are five requirements for securing a MAT waiver from SAMHSA:[52]

1. Active and valid state medical license (some states require a state-controlled substance license)
2. Drug Enforcement Administration registration to prescribe controlled substances
3. Eight hours of MAT waiver training or certification by an appropriate organization (free online and in-person training options are available)
4. SAMHSA waiver notification form
5. Ability to refer patients to counseling services

The AAFP shares and provides opportunities for family physicians to become MAT waivered with in-person and online training sessions. Providers Clinical Support System (PCSS) has multiple training formats, including online webinars for physicians and other health professionals. The Opioid Response Network also provides education and training, along with other resources, including technical assistance or feedback at a local level.

Extent of Practice

The extent of practice depends on the provider's comfort level (and that of the collaborating partner). Serious thought should be given to deciding what services will be offered (i.e., naltrexone only, buprenorphine only, treating stimulant use disorder, or any combination of these). Further consideration should be given about lab testing desired prior to intake, age range of the patients, and what type of collaboration is needed with mental health services and harm reduction strategies.

Evaluate Current Practice Systems and Workflow

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 those in order to address OUD in your practice.

Take a moment to examine how patients flow through your office. Create a simple document that shows how patients advance through your system, from the time they enter until the time they leave. Think about the following questions relative to OUD as you document your current workflow.[53,54]

- Where do patients go when they enter the office? What do they see and do before they are called back for their visit?
- Who do patients see before meeting the physician?
- What questions are asked when vital signs are measured?
- What information is exchanged with patients before the patient-clinician encounter?
- How do clinicians support OUD SBI and treatment during the encounter?
  - Do you make treatment goals and expectations clear to the patient?
  - Do you have an ability to perform rapid (immunoassay) and confirmatory (liquid chromatography and mass spectroscopy) urine drug screens?
  - Do you use a treatment agreement form that includes a plan of care (e.g., medication management, monitoring, program requirements and expectations) and informed consent?
  - Do you perform random or scheduled pill counts?
  - Do you check your state's prescription drug monitoring program (PDMP) to verify patient medication history?
- How is OUD SBI, counseling, and treatment documented?
  - Do you document encounters and patient calls thoroughly in the patient's record?
  - Could you report, track, and retrieve vitals and lab results in an EHR?
  - Could you perform standard billing and coding?
- Do all clinicians have a Drug Addiction Treatment Act 2000 (DATA 2000) waiver?
- Do all clinicians know their DATA 2000 waiver patient limits? Do you track when to formally apply to increase those limits (i.e., 30 for the first year, 100 for the second year, and 275 per year after that)?
- Have you kept a confidential log of patients which can be produced in the event of a Drug Enforcement Administration (DEA) inspection?
- Do you have community referral sources to expedite referral when a patient needs more than the MAT/MOUD your practice can offer?

After answering the questions above and evaluating your workflow, think about communication strategies, documenting patients with OUDs, and the systems you have or need to best treat patients with OUDs. To guide your process for improvement, answer the following questions with your care team.

1. How does your practice currently identify and document risky opioid use by patients? Which team member(s) are responsible for this?

2. How does your practice currently communicate to patients the health risks of opioid abuse/misuse and what is your ability to assist them? (select all that apply)
   - ☐ Posters in waiting areas
   - ☐ Posters in exam rooms
   - ☐ Self-help materials in waiting areas
   - ☐ Self-help materials in exam rooms
   - ☐ Lapel pins
   - ☐ Other

3. How does your practice currently help patients who are abusing or misusing opioids? (select all that apply)
   - ☐ Distribute educational materials
   - ☐ Refer patients to outside support groups, counseling, or OUD treatment options
   - ☐ Connect patients with harm reduction services, if needed
   - ☐ Provide prescription for naloxone
   - ☐ Counsel patients at visits
   - ☐ Provide follow up for patients tapering down their opioid use or attempting to quit
   - ☐ Offer Medication Assisted Treatment (MAT)

4. What systems do you have to address opioid abuse/misuse at patient visits? (select all that apply)
   - ☐ Prompts in electronic health record (EHR)
   - ☐ Screening protocols
   - ☐ Registry of patients who are prescribed opioids and may be at risk for abuse
   - ☐ Flags or stickers on paper charts
   - ☐ Feedback to clinicians on adherence to guidelines on opiate prescribing
   - ☐ Regular staff training
   - ☐ Other

5. Imagine that your practice is doing everything possible to help patients reduce or quit risky opioid use. How would that look?

6. What are some challenges you face in identifying patients who use opioids at risky levels to help them reduce opioid use or diagnose OUD?

7. What has worked in terms of helping patients reduce or quit opioid use? What has not worked?

8. Which team members' responsibility is it to advise patients to reduce opioid use or quit and to provide counseling and resources?

9. What resources are available in your community that your patients could access for help with their quit attempts?

Create a New Workflow

Based on your observations, create a new workflow that addresses the aforementioned questions. The following is one example of how patients could flow through your practice.

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 SBI and provide continuing education credits and other incentives for participation. The PCSS, Mountain Area Health Education Center (MAHEC), and ASAM provide options for continuing education. The resource section in this document has more information about these organization's training and other resources.

While utilizing all MAT-waivered health care, team members and other staff can help incorporate opioid SBI cost-effectively and efficiently while providing outstanding care to patients. All staff members to be considered in your efforts include:

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

While the family physician serves as lead for the team, each team member should know their role in OUD screening and treatment. As you develop the new workflow for your practice, make note of who will be performing each step, and include checkpoints to ensure a system of change occurs. As you begin to implement screening, brief interventions, and treatment into practice, there will be a need for new tools and resources for your team. Many of these are available on the AAFP's Pain Management & Opioid Misuse webpage.

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 available, or care is coordinated and referred to behavioral health counselor
- ☐ Plan for future visits: maintenance of MAT and counseling, reassess, and revisit goals
- ☐ Patient leaves

Payment and Coding

Lastly, but importantly, ensure that you are reimbursed for you and your care team's time with patients. 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 December 2020) can be found in the tables below.

Opioid Diagnosis

ICD 10	DESCRIPTION	GUIDANCE
F11.10	Opioid abuse, uncomplication	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.11	Opioid abuse, in remission	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.120	Opioid abuse with intoxication, uncomplicated	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.121	Opioid abuse with intoxication, delirium	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.122	Opioid abuse with intoxication with perceptual disturbance	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.129	Opioid abuse with intoxication, unspecified	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.14	Opioid abuse with opioid-induced mood disorder	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.181	Opioid abuse with opioid-induced sexual dysfunction	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.182	Opioid abuse with opioid-induced sleep disorder	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.188	Opioid abuse with other opioid-induced disorder	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
F11.19	Opioid abuse with unspecified opioid-induced disorder	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99
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	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.220	Opioid dependence with intoxication, uncomplicated	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.221	Opioid dependence with intoxication delirium	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.222	Opioid dependence with intoxication with perceptual disturbance	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.229	Opioid dependence with intoxication, unspecified	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.23	Opioid dependence with withdrawal	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.24	Opioid dependence with opiod-induced mood disorder	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99

ICD 10	DESCRIPTION	GUIDANCE
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusion	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.281	Opioid dependence with opioid-induced sexual dysfunction	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.282	Opioid dependence with opioid-induced sleep disorder	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.288	Opioid dependence with other opioid-induced disorder	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.29	Opioid dependence with unspecified opioid-induced disorder	F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.90	Opioid use, unspecified, uncomplicated	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.920	Opioid use, unspecified with intoxication, uncomplicated	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.921	Opioid use, unspecified with intoxication delirium	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.922	Opioid use, unspecified with intoxication with perceptual disturbance	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.929	Opioid use, unspecified with intoxication, unspecified	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.93	Opioid use, unspecified with withdrawal	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.94	Opioid use, unspecified with opioid-induced mood disorder	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99

ICD 10	DESCRIPTION	GUIDANCE
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.981	Opioid use, unspecified with opioid-induced sexual dysfunction	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.982	Opioid use, unspecified with opioid-induced sleep disorder	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.988	Opioid use, unspecified with other opioid-induced disorder	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder	F11.1X cannot be billed with F11.2-F11.29 or F11.9-F11.99 / F11.2X cannot be billed with F11.1-F11.19 or F11.9-F11.99
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, sequla	
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	
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	
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	

ICD 10	DESCRIPTION	GUIDANCE
T40.2X5A	Adverse effect of other opioids, initial encounter	
T40.2X5D	Adverse effect of other opioids, subsequent encounter	
T40.2X5S	Adverse effect of other opioids, sequela	
T40.2X6A	Underdosing of other opioids, initial encounter	
T40.2X6D	Underdosing of other opioids, subsequent encount	
T40.2X6S	Underdosing of other opioids, sequela	
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, sequaela	
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	
T40.4X1A	Poisoning by other synthetic narcotics, accidental (unintentional), Initial encounter	
T40.4X1D	Poisoning by other synthetic narcotics, accidental (unintentional), subsequent encounter	

ICD 10	DESCRIPTION	GUIDANCE
T40.4X1S	Poisoning by other synthetic narcotics, accidental (unintentional), sequela	
T40.4X2A	Poisoning by other synthetic narcotics, intentional self-harm, initial encounter	
T40.4X2D	Poisoning by other synthetic narcotics, intentional self-harm, subsequent encounter	
T40.4X2S	Poisoning by other synthetic narcotics, intentional self-harm, sequela	
T40.4X3A	Poisoning by other synthetic narcotics, assault, initial encounter	
T40.4X3D	Poisoning by other synthetic narcotics, assault, subsequent encounter	
T40.4X3S	Poisoning by other synthetic narcotics, sequela	
T40.4X4A	Poisoning by other synthetic narcotics, undetermined, initial encounter	
T40.4X4D	Poisoning by other synthetic narcotics, undetermined, subsequent encounter	
T40.4X4S	Poisoning by other synthetic narcotics, undetermined, sequela	
T40.4X5A	Adverse effect of other synthetic narcotics, initial encounter	
T40.4X5D	Adverse effect of other synthetic narcotics, subsequent encounter	
T40.4X5S	Adverse effect of other synthetic narcotics, sequela	
T40.4X6A	Underdosing of other synthetic narcotics, initial encounter	
T40.4X6D	Underdosing of other synthetic narcotics, subsequent encounter	
T40.4X6S	Underdosing of other synthetic narcotics, sequela	
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	

ICD 10	DESCRIPTION	GUIDANCE
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	
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	
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	
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	
Z71.51	Drug abuse counseling and surveillance of drug abuser	
Z71.89	Other specified counseling	Z71.89 is not a valid primary diagnosis

Opioid Procedural Codes

CPT HCPCS	PAYMENT LIMITATIONS	DESCRIPTION
80305	Statutory Exclusion CLIA Waived Test	Drug test, read by direct optical observation only
99202		Office or outpatient visit, new patient, level 2
99203		Office or outpatient visit, new patient, level 3
99204		Office or outpatient visit, new patient, level 4
99205		Office or outpatient visit, new patient, level 5
99211		Office or outpatient visit, established patient, physician presence not required
99212		Office of outpatient visit, established patient, level 2
99213		Office of outpatient visit, established patient, level 3
99214		Office of outpatient visit, established patient, level 4
99215		Office of outpatient visit, established patient, level 5
99408	Non-covered by Medicare	Alcohol and/or substance abuse screening with brief intervention; 15-30 min
99409	Non-covered by Medicare	Alcohol and/or substance abuse screening with brief intervention; >30 min
99484		Behavioral Health Care Management, 20+ min clinical staff time, physician or QHCP directed, per month
99XXX	PENDING	**NEW in 2021** - Prolonged service
G0396		Alcohol and/or substance abuse assessment with brief intervention; 15-30 min
G0397		Alcohol and/or substance abuse assessment with brief intervention; >30 min
G2067	Statutory Exclusion	M.A.T., methadone; weekly (Medicare OTP)
G2068	Statutory Exclusion	M.A.T., buprenorphine (oral); weekly (Medicare OTP)
G2069	Statutory Exclusion	M.A.T., buprenorphine (injectable); weekly(Medicare OTP)
G2070	Statutory Exclusion	M.A.T, buprenorphine (implant insertion); weekly (Medicare OTP)
G2071	Statutory Exclusion	M.A.T., buprenorphine (implant removal); weekly (Medicare OTP)
G2072	Statutory Exclusion	M.A.T., buprenorphine (implant insertion and removal); weekly (Medicare OTP)
G2073	Statutory Exclusion	M.A.T., naltrexone; weekly (Medicare OTP)
G2074	Statutory Exclusion	M.A.T., weekly bundle not including the drug, (Medicare OTP)
G2075	Statutory Exclusion	M.A.T., medication not otherwise specified; weekly (Medicare OTP)
G2076	Statutory Exclusion	Intake initial exam, physical and assessment by physician or a PCP, or authorized health care professional under supervision of physician qualified personnel (Medicare OTP); list separately in addition to code for primary procedure
G2077	Statutory Exclusion	Periodic assessment; by qualified personnel (Medicare OTP); list separately in addition to code for primary procedure
G2078	Statutory Exclusion	Take home supply of methadone; up to 7 additional day supply (Medicare OTP); list separately in addition to code for primary procedure
G2079	Statutory Exclusion	Take home supply of buprenorphine (oral); up to 7 additional day supply (Medicare OTP); list separately in addition to code for primary procedure
G2080	Statutory Exclusion	Each additional 30 minutes of counseling in a week of M.A.T, (Medicare OTP); list separately in addition to code for primary procedure
G2086		Office-based treatment for opioid use disorder; 70+ minutes in the first calendar month
G2087		Office-based treatment for opioid use disorder; 60+ minutes in a subsequent calendar month
G2088		Office-based treatment for opioid use disorder; each additional 30 min beyond first 120 minutes (list separately in addition to code for primary procedure)
GPC1X	PENDING	**NEW in 2021** - E/M Visit complexity
H0033	Non-covered by Medicare	Oral medication administration, direct observation
H0049	Non-covered by Medicare	Alcohol and/or drug screening
H0050	Non-covered by Medicare	Alcohol and/or drug services, brief intervention, per 15 minutes
Q9991	Excluded from physician fee schedule	Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg
Q9992	Excluded from physician fee schedule	Injection, buprenorphine extended-release (Sublocade), >100 mg

Auriculotherapy

64999	Payer Review & Pricing	Unlisted procedure, nervous system
97810	Non-covered by Medicare for Opioid Treatment	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Non-covered by Medicare for Opioid Treatment	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Non-covered by Medicare for Opioid Treatment	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Non-covered by Medicare for Opioid Treatment	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
A4212	Medicare - Bundled or excluded	Noncoring needle or stylet with or without catheter
S8930	Non-covered by Medicare	Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with patient

Resources (Available Online)

Laws Pertaining to Opioid Use

- Substance Abuse and Mental Health Services Administration (SAMHSA) — Laws and Regulations
- American Society of Addiction Medicine (ASAM) – Prescription Drug Monitoring Programs (PDMPs)

Treating OUD

- Becoming MAT Waivered
  - Providers Clinical Support System – Waiver Training for Physicians
  - American Society of Addiction Medicine (ASAM) — The ASAM Treatment of Opioid Use Disorder Course
- Practitioner Locator
  - Substance Abuse and Mental Health Services Administration (SAMHSA) — Buprenorphine Practitioner Locator
- Medications for OUD with Treatment Table
  - American Society of Addiction Medicine (ASAM) — The ASAM National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use
  - Providers Clinical Support System (PCSS) — Overview of Medications for Addiction Treatment
  - American Medical Association (AMA) Opioid Task Force — Help save lives: Co-prescribe naloxone to patients at risk of overdose
  - American Medical Association (AMA) — New guidance: Who can benefit from naloxone co-prescribing
  - *American Family Physician (AFP)* — Buprenorphine Therapy for Opioid Use Disorder
- Behavioral Health Interventions
  - Substance Abuse and Mental Health Services Administration (SAMHSA) — Brief Interventions and Brief Therapies for Substance Abuse
- Scripts for Assessment, Intervention, and Referral
  - National Institute on Drug Abuse (NIDA) — Motivating Patients to Initiate Treatment in the ED
- Shared Decision Making
  - Substance Abuse and Mental Health Services Administration (SAMHSA) — Shared Decision-Making Tools
- Trauma-Informed Care
  - National Conference of State Legislatures — Opioids & Early Adversity: Connecting Childhood Trauma and Addiction

Implementing in Practice

- Guidance on a Team-based Approach to Opioid Management
  - University of Washington Department of Family Medicine and Kaiser Permanente Washington Health Research Institute — Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care
- Guidance on Incorporating Behavioral Health
  - *FPM* — Bringing Behavioral Health Into Your Practice Through a Psychiatric Collaborative Care Program
  - Center of Excellence for Integrated Health Solutions – Resources for Assessing Organizational Readiness, Building the Business Case, and Workforce Development

Ongoing Training and Support

- MAHEC – Project ECHO® Continuing Education
- Providers Clinical Support System – Waiver Training for Physicians
- American Society of Addiction Medicine (ASAM) – The Treatment of Opioid Use Disorder Course

E-Visits

- Providers Clinical Support System (PCSS) — Frequently Asked Questions (and Answers): Treating Opioid Use Disorder via Telehealth Tips for Primary Care Providers
- Substance Abuse and Mental Health Services Administration (SAMHSA) — Virtual Recovery Resources

Addressing Health Disparities in OUD Treatment

- U.S. Department of Health and Human Services — The Opioid Crisis and Racial/Ethnic Minority Populations Webinar Series. Advocating for Prevention in Communities of Color: The Role of Providers Amid the Opioid Crisis
- Foundation for Opioid Response Efforts — Racial Disparities in Accessing Evidence-Based OUD Treatment and the Impact of the COVID-19 Pandemic

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