Emergency Department (ED): A Unique Opportunity to Save Lives Using Buprenorphine/Naloxone

**Stabilizing patients with ICD-10 opioid dependence or withdrawal**

<table>
<thead>
<tr>
<th>ED presentation</th>
<th>Assess</th>
<th>Treat</th>
<th>Discharge &amp; refer to treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Seeking treatment for opioid dependence</td>
<td>For moderate to severe opioid withdrawal (Use clinical judgment or COWS* score ≥ 8)</td>
<td>• Administer 4 to 8 mg buprenorphine based on severity of withdrawal</td>
<td>• Provide opioid overdose education and prescribe naloxone</td>
</tr>
<tr>
<td>• Complication of opioid use (e.g., withdrawal, overdose, injection site abscess)</td>
<td>OR</td>
<td>• Can re-dose every hour until withdrawal symptoms resolve (max total daily dose = 24 mg)</td>
<td>• Provide patient with a written follow-up plan</td>
</tr>
<tr>
<td>• Clinical suspicion for opioid dependence identified during course of visit</td>
<td><strong>Opioid dependence</strong> (see back of handout for more information)</td>
<td>• Buprenorphine can be administered in the ED to relieve acute withdrawal symptoms for up to 72 hours (X-waiver not required) to bridge patient until outpatient care is available</td>
<td>• Refer patient to outpatient provider for maintenance treatment</td>
</tr>
</tbody>
</table>

If there are complicating factors such as acute liver failure, pregnancy ≥ 20 weeks, or intoxication with substances other than opioids, consider consultation with a specialist.

Buprenorphine can be administered in the ED to relieve acute opioid withdrawal without an X-waiver.*6,7

ED providers across the country have developed strategies to increase access to care and reduce stigma for those with addiction.6,8

*Ability to intervene at a critical moment in the addiction cycle (e.g., overdose and withdrawal).1

Patients currently experiencing consequences of opioid use may be more motivated to change.2

Frequency of ED visits and non-fatal overdose have been associated with increased risk of drug overdose death.4,5

*Compared to making a referral + a brief intervention. **See FAQ #2 for more information.

*ED presentation

**COWS = Clinical Opiate Withdrawal Scale (can be found in the electronic medical record); Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; > 36 = severe withdrawal. *Buprenorphine refers to buprenorphine/naloxone in this document.
Diagnosing ICD-10 opioid dependence

Buprenorphine/naloxone is FDA-approved for opioid dependence. ICD-10, the official VHA nomenclature, defines opioid dependence as the presence of at least three of these features at any one time during the past year:

1. A strong desire or sense of compulsion to take opioids (craving)
2. Difficulties in controlling opioid use (onset, termination, or levels of use)
3. A physiological withdrawal state
4. Tolerance
5. Progressive neglect of alternative interests because of opioid use
6. Persisting with opioid use despite evidence of harmful consequences

Buprenorphine/naloxone is FDA-approved for opioid dependence. ICD-10, the official VHA nomenclature, defines opioid dependence as the presence of at least three of these features at any one time during the past year:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
<th>Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term current use of opiate analgesic</td>
<td>Z79.891</td>
<td>Patients may manifest opioid tolerance, withdrawal, and up to one symptom of “aberrant behavior” such as difficulty tapering</td>
</tr>
<tr>
<td>Opioid abuse</td>
<td>F11.1x</td>
<td>Opioid misuse, but not tolerance and withdrawal</td>
</tr>
<tr>
<td>Opioid dependence</td>
<td>F11.2x</td>
<td>Three or more features; correlates to moderate-severe opioid use disorder; treatment with buprenorphine should be offered</td>
</tr>
</tbody>
</table>

FAQs

1. Will patients flock to the ED if we start offering buprenorphine?
   No, EDs with buprenorphine protocols report that this has not happened. Patients with opioid dependence are already in your ED whether for overdose or for other reasons, such as asthma exacerbations or hyperglycemia. Buprenorphine treatment improves the likelihood that patients with opioid dependence will follow through with outpatient care, rather than repeatedly turning to the ED for “crisis” management.

2. Do I need an X-waiver to administer buprenorphine in the ED?
   No. Federal regulations allow non-X-waivered providers to administer buprenorphine in the ED for up to 72 hours to treat opioid withdrawal. An X-waiver is required to prescribe buprenorphine upon ED discharge. For information on how to obtain an X-waiver, go to: samhsa.gov/medication-assisted-treatment

3. Does the patient need to be observed in the ED until all withdrawal symptoms subside?
   No. Buprenorphine administration with adequate titration (cardiac monitoring not required) can alleviate withdrawal and reduce the risk of opioid use after ED discharge. Rapid referral is necessary for maintenance treatment. Work with your local SUD treatment program to develop a rapid referral process.
   NOTE: Only an X-waivered provider can prescribe buprenorphine for home initiation.

4. What is the worst thing that could happen after I administer buprenorphine?
   If the patient has other opioids on board, buprenorphine can induce precipitated withdrawal. This risk can be minimized by assessing for last opioid use and conducting a COWS assessment. If precipitated withdrawal occurs, it can be mitigated with supportive medications for symptoms and/or higher doses of buprenorphine.