Quality Tip Sheet

# Concurrent Use of Opioids and Benzodiazepines

Independence Blue Cross (IBX) offers Quality Tip Sheets that provide information about the Concurrent Use of Opioids and Benzodiazepines performance measure and best practices for prescribing opioids.

## Risks of Combining Opioids and Benzodiazepines

- Opioid use with benzodiazepines can stop breathing and lead to an accidental overdose and fatal respiratory suppression.[1]
- The risk of opioid-related overdose is five times higher during the first 90 days when benzodiazepines are also used.[1]
- Combined use increases impaired cognition, extreme sedation, and risks of falls, fractures, or motor vehicle accidents, particularly in older adults.[2]
- Concurrent prescribing is linked to more emergency department visits, hospitalizations, and drug-related emergencies.[3]

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[1] Hernandez I, He M, Brooks MM, Zhang Y. Exposure-Response Association Between Concurrent Opioid and Benzodiazepine Use and Risk of Opioid-Related Overdose in Medicare Part D Beneficiaries. *JAMA Netw Open*. 2018;1(2):e180919. doi:10.1001/jamanetworkopen.2018.0919

[2] Shah R, Raji MA, Westra J, et al Association of co-prescribing of opioid and benzodiazepine substitutes with incident falls and fractures among older adults: a cohort study *BMJ Open* 2021;11:e052057. doi: 10.1136/bmjopen-2021-052057

[3] Benzodiazepines and Opioids, National Institute on Drug Abuse, November 7, 2022

[4] Opioid Use Disorder: Diagnosis | Overdose Prevention | CDC

[5] Prescription Opioid Use Disorder Among Adults Reporting Prescription Opioid Use With or Without Misuse in the United States


## Best Practices and Tips

**Medication review**

During an annual medication review, assess all medications for deprescribing opportunities, document with appropriate CPT® codes, and consider formulary alternatives from other medication classes.

**Non-pharmacologic alternatives**

Offer alternative, non-opioid approaches, such as cognitive behavioral therapies, interdisciplinary rehabilitation, physical therapy, and exercise.



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## Best Practices and Tips

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| **Risk assessment** | Before prescribing opioids, evaluate risk factors for opioid-related harms and have a signed Opioid Patient Prescriber Agreement in the medical record. |
| **Prescription monitoring** | Check the prescription drug monitoring program prior to prescribing opioids and benzodiazepines every three months when continuing opioid therapy. |
| **Evidence-based treatment** | Arrange for or ensure evidence-based treatment for patients with Opioid Use Disorder (buprenorphine, methadone, and recovery support services). |
| **Rescue medication** | Given the high risks of concurrent use, offer rescue medication like Naloxone, to patients and their caregivers. Naloxone can be prescribed for any household concerns. For example, if household members, including children, or other close contacts accidentally ingest or experience an opioid overdose having naloxone nearby is critical. |
| **Tapering resources** | To help with tapering benzodiazepines, consider resources offered by CMS, including Helping Patients Taper from Benzodiazepines. |
| **Diagnosis accuracy** | Review all active diagnoses annually and submit updated ICD-10 codes through claims to ensure accuracy. |

## Exclusions

- Members with the below diagnoses and/or in hospice or receiving palliative care are excluded from the measure.
- Members diagnosed with cancer or sickle cell disease.

## Potential diagnostic considerations for providers

- For patients using long-term medication for pain and not meeting the DSM-V criteria for substance use disorder (SUD), providers may consider code Z79.891 (long-term current use of opiate analgesic).
- If a patient is taking a prescribed medication under proper medical supervision, the DSM-V does not count "tolerance" and "withdrawal" (criteria 10 and 11) toward an SUD diagnosis. In these cases, the patient must meet at least two other DSM-V criteria (excluding tolerance and withdrawal) to be diagnosed with SUD.[4, 5]
- A "1" at the end of an SUD diagnosis code, indicates the condition is in remission, e.g., F10.11, (alcohol use disorder, mild, in early or sustained remission). Early remission is defined by no symptoms for at least 3 months, but less than 12 months. Sustained remission is defined as no symptoms for 12 months or longer.

## Resources

For more information about co-prescribing opioids and benzodiazepines, prescribing opioids for chronic pain, and non-opioid treatment alternatives, refer to the following resources:

- American Society of Addiction Medicine. (2025). *Joint clinical practice guideline on benzodiazepine tapering: Considerations when benzodiazepine risks outweigh benefits*. Joint CPG on BZD Tapering
- Centers for Disease Control and Prevention (CDC)
  - CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR
  - Nonopioid Therapies for Pain Management | Overdose Prevention | CDC