

Chapter 8 – Alcohol and Drug Abuse
Subchapter 6

Rules Governing Medication-Assisted Therapy for Opioid Dependence for:
1. Office-Based Opioid Treatment (OBOT) Providers Prescribing Buprenorphine
2. Opioid Treatment Providers (OTP) –State Regulations

1.0 Authority

These rules are established pursuant to 18 V.S.A. § 4752 and Act 195 § 14 of 2013.

2.0 Purpose

This rule establishes minimum requirements for authorized Office Based Opioid Treatment Providers (OBOT) to prescribe, and in limited circumstances, dispense buprenorphine to individuals requiring and seeking treatment for opioid addiction. The rule also establishes Vermont-specific requirements for Opioid Treatment Programs that are in addition to the regulatory requirements of 42 CFR, Part 8.

3.0 Definitions

- 3.1 “ADAP” means the Division of Alcohol and Drug Abuse Programs in the Vermont Department of Health.
- 3.2 “ADAP Preferred Providers” means specialty substance abuse treatment services certified, approved and audited by ADAP who may work with OBOT providers known as Spokes or who may work with OTPs known as Hubs.
- 3.3 “Administrative Discharge” means the involuntary process of medically supervised withdrawal from MAT.
- 3.4 “Clinical Discharge” means the voluntary process, agreed upon by both the patient and provider, of medically-supervised withdrawal from MAT by gradually tapering medication for ultimate cessation of opioid replacement therapy.
- 3.5 “DATA 2000” means the federal Drug Addiction Treatment Act of 2000, which permits providers who meet certain qualifications to treat individuals with opioid

addiction by prescribing Food and Drug Administration-approved medications such as buprenorphine.

- 3.6 “DATA 2000 Waiver” means an authorization for a licensed provider who has met the training and credentialing registration requirements of DATA 2000 to prescribe specified opioid addiction drugs to patients in settings other than Opioid Treatment Programs (OTP’s).
- 3.7 “DEA” means the Drug Enforcement Administration in the U.S. Department of Justice.
- 3.8 “DEA Number” means the Drug Enforcement Administration number assigned to each provider granting them authority to prescribe controlled substances.
- 3.9 “Diversion” means the illegal use of a prescribed controlled substance for a use other than that for which the substance was prescribed.
- 3.10 “DVHA” means the Department of Vermont Health Access in the Agency of Human Services.
- 3.11 “Eligible provider” means a Vermont-licensed physician, physician assistant or advanced practice registered nurse, or other provider allowed to prescribe MAT under federal law and regulation.
- 3.12 “Informed consent” means agreement by a patient to a medical procedure, or for participation in a medical intervention program, after achieving an understanding of the relevant medical facts and the risks involved. This includes an understanding of medication risks and benefits.
- 3.13 “Maintenance Treatment” means long-term MAT typically provided by an OBOT for an addiction lasting longer than one year.
- 3.14 “MAT” means medication-assisted therapy to treat opioid dependence. Both methadone and buprenorphine are examples of MAT drugs. MAT may also be referred to as Opioid Replacement Therapy.
- 3.15 “OBOT” means Office Based Opioid Treatment provider practice for prescribing buprenorphine as established by the Drug Abuse and Treatment Act of 2000. In

Vermont, OBOTs are often referred to as “Spokes”. An OBOT may be a preferred provider, an individual provider practice or several providers practicing as a group.

- 3.16 “OTP” means an Opioid Treatment Program as defined and regulated by federal regulation 42 CFR, Part 8 and DEA regulations related to safe storage and dispensing of OTP’s (§1301.72). OTP’s are specialty addiction treatment programs for dispensing opioid-replacement medication including methadone and buprenorphine under carefully controlled and observed conditions. OTPs offer onsite ancillary services. In Vermont, OTPs are sometimes referred to as “Hubs”.
- 3.17 “Physician” means a licensed medical doctor or a licensed doctor of osteopathy as described in 26 V.S.A. Ch. 23 subchapter 3.
- 3.1.8 “Provider” means a health care provider as defined by 18 V.S.A. 9402. A person, partnership, or corporation, other than a facility or institution, licensed or certified or authorized by law to provide professional health care service in this State to an individual during that individual's medical care, treatment, or confinement.
- 3.19 “Psychosocial Assessment” means an evaluation of the psychological and social factors that are experienced by an individual or family as the result of addiction. The factors may complicate an individual’s recovery or act as assets to recovery.
- 3.20 “SAMHSA” means the Substance Abuse and Mental Health Services Administration, an agency under the U.S. Department of Health and Human Services.
- 3.21 “Toxicology Tests” means any laboratory analysis of urine, oral mucosa, or serum blood for the purpose of detecting the presence of alcohol and/or various scheduled drugs.
- 3.22 “VPMS” means the Vermont Prescription Monitoring System, the statewide electronic database that collects data on Schedule II, III, or IV controlled substances dispensed in Vermont.

4.0 Requirements for eligible providers to Prescribe Buprenorphine as Treatment for Opioid Dependence

4.1 Prior to prescribing buprenorphine, all eligible providers shall:

- 4.1.2 Hold a Vermont license and a DEA number.

4.1.3 Receive a DATA 2000 waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA).¹

4.2 Patient Load Limitations for Eligible Providers

4.2.1 30 or Fewer Patients

During the first year prescribing buprenorphine, an eligible provider may maintain a patient load of up to 30 or fewer individuals receiving MAT at any point in time.

4.2.2 100 or Fewer Patients

After one year of prescribing to 30 or fewer patients, an eligible provider may apply for a waiver from SAMHSA to treat a maximum of 100 patients.

4.2.3 275 or Fewer Patients

After one year of prescribing under a waiver to treat a maximum of 100 patients, an eligible physician may apply to SAMHSA for a waiver to treat up to 275 patients. Eligible physicians must reapply for a 275-patient waiver every three years.

5.0 OBOT Program Administration and Operations Requirements

5.1 All Vermont OBOTs shall have and maintain all of the following in order to initiate and continue prescribing buprenorphine:

5.1.1 Office or facility with sufficient space and adequate equipment to provide quality patient care and monitoring.

5.1.2 Office space that is clean, well-maintained and has appropriate climate controls for patient comfort and safety.

5.1.3 Adequate space for private conversations if psychosocial assessment and counseling services are provided on-site.

¹ http://buprenorphine.samhsa.gov/waiver_qualifications.html

- 5.1.4 Office space adequate for the protection of all confidential medical information and records in hard-copy or electronic formats.
- 5.1.5 Adequate referral arrangements with other providers and practitioners to evaluate and treat all medical and psychological issues that any patient may experience. This ensures that MAT is provided in the context of any other health issues the patient may have.

5.2 Emergency and Closure Preparedness

5.2.1 Continuity of Services for Unexpected Temporary Closure

Each OBOT shall develop and maintain a written plan for the administration of medications in the event of a temporary closure due to inclement weather, provider illness or similar unanticipated service interruptions. The plan shall include:

- 5.2.1.1 A plan for a reliable mechanism to inform patients of these emergency arrangements.
- 5.2.1.2 The identification of emergency procedures for obtaining prescriptions/access to medications in case of temporary program/office closure. This may include an agreement with another provider authorized to prescribe buprenorphine or with an OTP. It may also include the ability to transfer patient records.

5.2.2 Permanent Program Closure

Each OBOT shall have a written plan for continuity of care in the event that a future voluntary or involuntary program closure occurs. Programs shall have an operational plan for managing a program closure. The plan shall include:

- 5.2.2.1.1 A plan for the orderly and timely transfer of patients to another OBOT provider.

- 5.2.2.2 A plan to notify patients of any upcoming closure and reassure them of transition plans for continuity of care.
- 5.2.2.3 A plan to notify ADAP and DVHA no fewer than 60 days prior to closure to discuss the rationale for closure, and plans for continuity of care.
- 5.2.2.4 A plan for the transfer of patient records to another OBOT provider.
- 5.2.2.5 A plan to ensure that patient records are secured and maintained in accordance with State and Federal regulations.

6.0 Clinical Care and Management Requirements

6.1 Acceptance for Buprenorphine Treatment (MAT)

Prior to commencing MAT, and in addition to ensuring that any patient has a comprehensive medical evaluation as described in Section 6.2.1, the OBOT provider shall assess the patient and diagnose and document an opioid use disorder as defined by either the current edition of the Diagnostic and Statistical Manual of Mental Disorders, or the current edition of the International Classification of Diseases.

6.2 Evaluation of the Patient's Health Status

6.2.1 Medical Evaluation

Prior to commencing MAT, the provider shall either conduct an intake examination that includes any relevant physical and laboratory tests, or refer the patient to a medical professional who can perform such an examination.

6.2.2 Psychosocial Assessment and Referral to Services

- 6.2.2.1 The psychosocial assessment shall be completed before the fourth patient visit to the provider prescribing or dispensing MAT. The psychosocial assessment must be completed by a

provider who is a licensed Psychiatrist, a physician certified by the American Board of Addiction Medicine, a Psychiatric Nurse Practitioner, a Psychiatric Physician Assistant, a licensed mental health/addictions clinician such as a Licensed or Certified Social Worker, a Psychologist, a Licensed Mental Health Counselor, a Licensed Marriage and Family Therapist or a Licensed Alcohol and Drug Abuse Counselor. If the prescribing provider is not certified in one of these disciplines then the patient shall be referred for the psychosocial assessment.

- 6.2.2.2 If the provider prescribing or dispensing buprenorphine does not meet any of the specifications in Section 6.2.2.1, a referral to a provider who does meet those specifications must be made for a psychosocial assessment. The referral must be made before the fourth patient visit to the provider prescribing or dispensing MAT and shall be documented in the patient's record.
- 6.2.2.3 Based on the outcomes of the psychosocial assessment, the provider may recommend to the patient that he or she should participate in ongoing counseling or other behavioral interventions such as recovery programs.
- 6.2.2.4 A provider may not deny or discontinue MAT based solely on a patient's decision not to follow a recommendation to seek counseling or other behavioral interventions unless the patient is otherwise non-compliant with program expectations.

6.3 Developing a MAT Treatment Plan

- 6.3.1 Individuals who are clinically indicated for methadone therapy, or who need more clinical oversight or structure than available through an OBOT, shall be referred to an appropriate OTP.
- 6.3.2 Providers dispensing buprenorphine from an OBOT setting shall register with VPMS and comply with Vermont's VPMS rule regarding reporting on dispensed controlled substances.

6.3.3 The OBOT provider prescribing buprenorphine shall adhere to all applicable standards of medical practice for providing treatment.

6.4 Informed Consent and Patient Treatment Agreement

Templates for documents or references in Sections 6.4.1 through 6.4.3 are available on the Physician Clinical Support System website. A link to the website shall be maintained on the Department's web page.

Prior to treating a patient with buprenorphine, a provider shall:

6.4.1 Obtain voluntary, written, informed consent to treatment from each patient.

6.4.2 Obtain a treatment agreement outlining the responsibilities and expectations of the prescribing provider and the patient.

6.4.3 Make reasonable efforts to obtain releases of information for any health care providers or others important for the coordination of care to the extent allowed by Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR, Part 2.

6.5 Ongoing Patient Treatment and Monitoring

Beyond adhering to standard clinical practices, the following provisions must be followed by OBOT providers:

6.5.1 Referral and Consultation Network Requirements

6.5.1.1 Each OBOT provider shall maintain a referral and consultative relationship with a range of providers capable of providing primary and specialty medical services and consultation for patients receiving MAT.

6.5.1.2 Exchanges of information across this network shall facilitate patient treatment and conform to the protection of patient privacy consistent with HIPAA and for covered programs 42 CFR, Part 2.

6.5.2 Monitoring for Diversion

To ensure patient and public safety, each MAT provider shall develop clinical practices to minimize risk of diversion. These practices shall include the

following:

- 6.5.3.1 Querying VPMS as required by Vermont’s VPMS rule regarding system queries.
- 6.5.3.2 Informing patients on buprenorphine that diversion is a criminal offense.
- 6.5.3.3 Using the following clinical tools to monitor a patient’s conformity with his or her treatment agreement and for monitoring diversion:
 - Routine toxicological screens
 - Random requests for medication counts
 - Bubble-packaging of prescriptions, if in tablet form
 - Recording the ID numbers listed on the medication “strip” packaging for matching with observation of ID numbers during random call-backs.
- 6.5.3.4 Determining the frequency of monitoring procedures in 6.5.3.3 based on the unique clinical treatment plan for each patient and his or her level of stability. For patients receiving services from multiple providers, the coordination and sharing of toxicology results is expected.
- 6.5.3.5 Collecting all urine and toxicological specimens in a therapeutic context.
- 6.5.3.6 Addressing the results of toxicological tests promptly with patients

6.6 Administrative Discharge from MAT

- 6.6.1 The following situations may result in a patient being involuntarily discharged from MAT through medically supervised withdrawal:
 - 6.6.1.1 Disruptive behavior that has an adverse effect on the OBOT practice, staff or other patients. These include, but are not limited to:

- violence
- aggression
- threats of violence
- drug diversion
- trafficking of illicit drugs
- continued use of substances
- repeated loitering
- noncompliance with the treatment plan resulting in an observable, negative impact on the program, staff and other patients.

6.6.1.2 Incarceration or other relevant change of circumstance.

6.6.1.3 Violation of the treatment agreement.

6.6.1.4 Nonpayment of fees.

6.6.2 When an OBOT provider or practice decides to administratively discharge a patient from MAT, the provider will offer a clinically appropriate withdrawal schedule as long as it does not compromise the safety of providers or program staff.

6.6.1.2.1 A patient who is involuntarily discharged from MAT should be referred to another program that is more clinically appropriate or affordable for the patient.

6.6.1.2.2 All factors contributing to the involuntary discharge from the program shall be documented in the patient's record.

6.6.1.2.3 All efforts to refer the patient to a suitable alternative treatment program or to behavioral health services shall be documented in the patient's record.

6.7 Additional Requirements for Pregnant Women

6.7.1 Due to the risks of opioid addiction to pregnant women and their fetuses, a pregnant woman seeking buprenorphine from an OBOT shall either be admitted to the OBOT or referred to an OTP within 48 hours of initial contact.

- 6.7.2 OBOT providers unable to admit pregnant women, or unable to otherwise arrange for MAT care within 48 hours, shall notify ADAP within 48 hours to ensure continuity of care.
- 6.7.3 In the event that a pregnant woman is involuntarily withdrawn from MAT, for reasons specified in Section 6.6.1 of this rule, the provider shall refer the woman to the most appropriate obstetrical care available.

7.0 Requirements for OTPs

In addition to the OTP regulatory requirements of 42 CFR, Part 8, Vermont OTP's shall:

- 7.1 Query VPMS as required by the Vermont Prescription Monitoring System Rule. Because federal law prohibits the reporting of MAT dispensed from an OTP to a prescription monitoring system, other providers may be unaware of a patient's enrollment in an OTP for MAT.
- 7.2 In an emergency, a non-physician in an OTP may admit a patient for MAT treatment to avoid delays in treatment. In these situations, a MAT physician shall review the medical evaluation and substance use disorder diagnosis to certify the diagnosis within 72 hours of the patient being admitted to the program. The MAT physician shall certify the diagnosis in the patient's record and have either a face-to face meeting or contact through an approved form of communication technology to review the assessment and discuss medical services.
- 7.3 Review, update and document the patient's treatment plan quarterly during a patient's first year of continuous treatment. In subsequent years of treatment, a treatment plan shall be reviewed no less frequently than every 180 days.

Advanced practice registered nurses and physician assistants who are granted a SAMHSA waiver to order and dispense methadone and buprenorphine from an OTP shall comply with the requirements of Section 7 of this rule.

- 7.4 To the extent allowed by a signed release of information, notify each patient's primary care provider about plans for prescribing methadone treatment to the patient.