

MASSACHUSETTS



# OTP TTA CENTER

Opioid Treatment Program  
Training & Technical Assistance Center



# **Myth or Fact: What is Allowed in a Methadone Clinic?**

**March 31st, 3:30 - 4:30 pm**



# Presenters




**Phoebe Cushman, MD, MS**  
Program Physician,  
Spectrum Health Systems



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Behavioral Health Network

# Session Objectives

- 1 Describe the surrogacy process for delivering methadone to patients who cannot present to the OTP
  - 2 Review operations that allow patients to transition between methadone and buprenorphine treatment in the OTP setting
  - 3 Analyze the pros and cons of administering ECGs in the OTP setting
  - 4 Compare approaches for managing addiction-adjacent diseases in the OTP setting
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# DISCLOSURES

We have no actual or potential conflict of interest in relation to this presentation.



# Introduction

*“Almost everything is cutting edge when it comes to methadone”*—Chris Mulvey, FNP-BC

Narcotic Addict Treatment Act of 1974

OTP = opioid treatment program (“methadone clinic”)

COVID-19 (2020)

Changing landscape of methadone:

- take home flexibilities
- telehealth flexibilities

# Introduction

- Even before these recent changes, you could (usually) do more than you might expect in an OTP
- When you look through the regulations you might find
  - more rules than you expected
  - conflicting information
  - open-ended language
- Getting into the weeds
- Caveat—lots of experts in the audience



# Alphabet Soup



OTPs must be

Certified by Substance Abuse and Mental Health Services Administration (SAMHSA)

Registered with the Drug Enforcement Administration (DEA)

Licensed by the state in which they operate

Usually the Department of Public Health (DPH)

In MA, Bureau of Substance Abuse Services (BSAS) is part of DPH

Accredited by Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission

# MYTH: "Only the person taking the methadone can pick up the methadone"

Two key concepts:

- 1) Chain of custody form (CoC)
- 2) Qualified Service Organization Agreement (QSOA)



# MYTH: "Only the person taking the methadone can pick up the methadone"

## 1) Chain of custody form (CoC)

standardized document that tracks the handling, transfer, and receipt of controlled medications

*ensures accountability and prevents diversion* by

documenting each individual who takes possession of the medication, the quantity and dosage being transported, and the dates and times of transfer



# MYTH: "Only the person taking the methadone can pick up the methadone"

## 2) Qualified Service Organization Agreement (QSOA)

A written contract between a substance use disorder (SUD) program and an outside agency (a Qualified Service Organization, or QSO) that provides services

*Enables communication:*

“It allows 42 CFR Part 2 programs to get essential services from outside organizations without always needing to get patient consent for each disclosure”

*Protects confidentiality:*

“The agreement binds the QSO to the confidentiality rules of 42 CFR Part 2, ensuring patient-identifying information related to SUDS is protected”

# MYTH: "Only the person taking the methadone can pick up the methadone"

Arrangement	QSOA needed?	Chain of Custody needed?	Notes	Example
Surrogacy: Family & friends	no	yes	"reliable designated other"	Eye surgery/lives with mom
Surrogacy: Residential program	yes	yes	Multiple models	
Visiting Nurse Association (VNA)	yes	yes	Not all VNAs participate	Eye surgery/lives alone
OTP delivers to patients' home	no	yes		Early COVID-19
OTP delivers to a facility	yes	yes		SNF, jail or prison
Medication unit	no	no	extension of OTP license	Mobile unit, jail or prison, SNF

# MYTH:

## “You can’t get buprenorphine at an OTP”

How could this happen?

- 1) **Dispense** buprenorphine through the OTP (operational license; OP)
- 2) **Prescribe** buprenorphine using a Mental Health (MH) license
- 3) **Prescribe** buprenorphine using an **Office Based Opioid Treatment (OBOT)** license



# MYTH:

## “You can’t get buprenorphine at an

**OTP”** How could this happen?

### 1) **Dispense** buprenorphine through the OTP (OP license)

OTPs modify their DEA registration to add Schedule III narcotics

Pro: no additional license needed

bypass the stigma and delays of the pharmacy

Con: decreased flexibility for patients

most patients would rather fill at the pharmacy

billing mechanisms are limited

# MYTH:

## “You can’t get buprenorphine at an OTP”

- 2) Prescribe buprenorphine using a **Mental Health (MH)** license
- Additional licensing through Dept of Mental Health (DMH)
- Requires hiring of Psychiatrists and/or Psych NPs
- All medical providers can bill insurance under psychiatric codes
- Requires CARF accreditation

# MYTH:

## “You can’t get buprenorphine at an OTP”

- 3) Prescribe buprenorphine using an **Office Based Opioid Treatment (OBOT)** license
  - Additional licensing through BSAS
  - Requires reporting to BSAS
  - Nurse care manager (NCM) model
    - Does not require as many physicians/APC’s
    - Only certain setups (e.g. FQCHC) can bill for NCM visits
- Requires Joint Commission accreditation

# MYTH:

## “You can’t get buprenorphine at an OTP”

Now that we have both methadone and buprenorphine available in the same place, you can’t have a patient on both at the same time, can you?

- Wouldn’t that be *illegal*?

You cannot have a patient simultaneously enrolled in an OTP and a bup program, but you CAN prescribe buprenorphine to them while they are still enrolled in the OTP

- Can you bill for it?



# MYTH:

## “You can’t manage anything but OUD at an

### OTP”

Rationale for treating **addiction-adjacent diseases:**

Patients enter MOUD treatment during an exceptionally disruptive period

Active SUD

Post-carceral

Post-hospitalization

Post-ATS/CSS



Many are either without ready access to medical services or are not yet in a condition to access such services if available

Wait times for primary care intake appointment in Eastern Massachusetts range from 40 to 136 days

Health Care for All Massachusetts blog Aug 7, 2025

# Management of Addiction-Adjacent Disease

- OTP regulations do not prevent licensees from offering primary care and psychiatric services
- OTP licensing does not; however, confer practice privileges commensurate with general medical clinic licensure or mental health licensure
- Successful treatment of OUD is often dependent upon treatment of addiction-adjacent diseases
- OTPs reduce barriers to patients accessing myriad services across a range of concerns
  - Reduced stigma
  - Increased convenience
  - Improved rapport with mission-driven and properly trained staff

# Management of Addiction-Adjacent Disease

Potential Approaches for Onsite Care:

- Obtain DPH licensure for general medical practice or mental health

- QSOA with Community Health Center

  - Satellite clinic licensure

- QSOA with private practice physician or nurse practitioner

  - Would not require licensure

  - Would require distinct billing and electronic medical record as well as privacy protections during referral process

# Management of Addiction-Adjacent Disease

Facilitation of Referral from OTP to Onsite Primary Care or Psychiatry:

OTP may bill for provider assessment of further treatment needs

HCPSC code G2077: Periodic assessment

*“Assessing periodically by an OTP practitioner and includes a review of MOUD dosing, treatment response, other substance use disorder 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 (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to each primary code.”*

Suggest coordinating patient referrals via OTP provider consult

# MYTH: “You can’t do an ECG in an OTP”

## Rationale for administering electrocardiograms (ECGs)

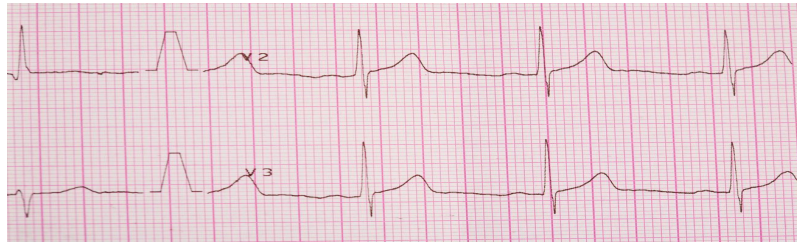
Methadone known to contribute to QTc prolongation

QTc prolongation □ Torsades de Pointe □ Potential death

EKG screening utilized as tool to reduce TdP risks

No definitive evidence to prove screening to be beneficial

Onsite EKGs reduce barriers to dose optimization in OTP population



# Onsite ECG

## Primary Considerations

- Electrocardiogram machine acquisition

- Liability concerns

## Secondary Considerations

- Workflow and Staffing Constraints

  - Cross-train MA, Nursing, & Provider Staff to administer

# Onsite ECG

## Considerations

Electrocardiogram machine acquisition

Typically \$1,500-5,000

Alternative: AliveCor KardiaMobile 6L

Pros: Cleared by FDA for QTc calculation, less invasive, less expensive, more limited results potentially decrease liability concerns

Cons: QTc needs to be calculated by hand



# Onsite ECG

## Considerations

### Liability concerns

- Include EKG consent form in admission packet

  - Indicate rationale and limitations of review

- Develop or revise EKG policy to include

  - Indications

  - Staff responsibilities

  - Procedure

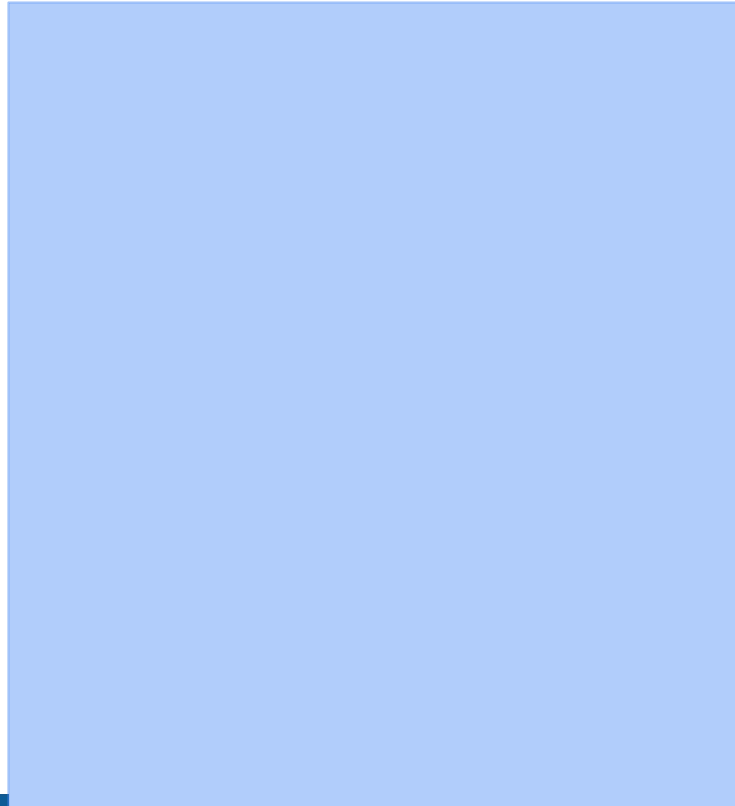
  - Indications for follow-up

  - Consider QSOA with primary care practice for urgent referrals

# Onsite ECG



# Onsite ECG



# Conclusions

- Offsite delivery of methadone is possible and permissible
- Patients may be transitioned from methadone to buprenorphine within an OTP, including pharmacy-based prescriptions
- Onsite ECGs are practical and improve the efficiency of OUD care provision, and policies can be developed to reduce liability
- OTP regulations do not prevent providers from offering addiction-adjacent services; however, additional licensure or partnerships are typically required

# REFERENCES

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# **Thank you!**

## **QUESTIONS?**

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