#	Category	Standard	Provisional Standard	Notes/Comments
1	Service Definition/ Required Components	Any opioid addiction treatment that includes a U.S. Food and Drug Administration (FDA) approved medication for the detoxification or maintenance treatment of opioid addiction (e.g., methadone, levo-alpha acetyl methadol [LAAM], buprenorphine, buprenorphine naloxone, naltrexone) along with counseling and other supports, including drug screen. Services may be provided in an Opioid Treatment Program (OTP), a medication unit affiliated with an OTP, or, with the exception of Methadone, a physician's office or other community based setting including the recipient's home/residence, homeless shelter, school (only if not an IEP covered service), or other community setting where the recipient may wish/need to receive a service. Providers are instructed through regulations that the confidentiality of the client must be maintained in any setting where a service may occur. MAT increases the likelihood for cessation of illicit opioid use or of prescription opioid abuse. MATs are non-residential and must comply with all state laws. Opioid Treatment Program or "OTP" means a substance abuse program using approved controlled substances and offering a range of treatment procedures and services for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug of that group. A "medication unit affiliated with an OTP" means a Medication Station or Dosing Location that obtains its drug supply from the main program site and retains all records (except dosing, screens) at the main location. Main program means the location of the MAT program where all administrative and medical information related to the narcotic treatment program is retained for the purpose of on-site reviews by federal agencies or the state narcotic authority or state opioid treatment authority designee. Service components include: • Individual and Group therapy • Dosing • Medication		Outside of what Medicaid will pay for, should we also include as components of services physical exams, medication monitoring, structured and phased incentives for program compliance (i.e., increasing take homes)

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		• Assessment and • Drug screens		
2	Provider Requirements / Qualifications	Authorized Providers: Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization – must obtain specific certification to deliver this service • Physician • Psychiatrist Billing Providers • Individual Practitioners o Physician o Psychiatrist • Provider Groups o Physician o Psychiatrist • Licensed Organizations	OTPs should hire individuals who are licensed or credentialed under State regulations and have a record of working effectively with the types of patients served by the OTP. **(TIP 43)** NTPs shall have a medical director who shall: (a) Be licensed by the Commonwealth of Kentucky to practice medicine within the Commonwealth and function autonomously within the NTP free from any protocol imposed by any NTP, sponsor, or any other entity except under the guidelines imposed by 42 C.F.R. Part 8 and this administrative regulation; and (b) Be a board eligible psychiatrist licensed to practice in Kentucky and have three (3) years documented experience in the provision of services to persons who are addicted to alcohol or other drugs; or (c) Be a physician licensed to	OTP staff members should be willing to work with people from diverse backgrounds, explore and accept other value systems, and understand how culture and values can relate to patients' behavior. Support staff should be accepting and understanding of patients from diverse groups because these staff members often are the first people a new patient sees at the OTP and those with whom the patient interacts most. If possible, management should recruit employees who reflect patient demographics and should consider hiring people who are recovering from addiction **(TIP 43)**

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			practice in Kentucky and certified as an addictionologist by the American Society of Addiction Medicine; and (d) Be responsible for dosing staff in the NTP and shall be responsible for the NTPs adherence to 42 C.F.R. Part 8, KRS Chapter 218A, 902 KAR 55:010 to 55:095, 908 KAR 1:370 and this administrative regulation. (2) NTPs may have a program physician who shall: (a) Be licensed by the Commonwealth of Kentucky to practice medicine within the Commonwealth and function autonomously within the NTP free from any protocol imposed by any NTP, sponsor, or any other entity except under the guidelines imposed by 42 C.F.R. Part 8 and this administrative regulation; and (b) Be a board eligible psychiatrist licensed to practice in Kentucky and have three (3) years documented experience in	

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			the provision of services to persons who are addicted to alcohol or other drugs; or (c) Be a physician licensed to practice in Kentucky and certified as an addictionologist by the American Society of Addiction Medicine; and (d) Be responsible for dosing staff in the NTP and shall be responsible for the NTPs adherence to 42 C.F.R. Part 8, KRS Chapter 218A, 902 KAR 55:010 to 55:095, 908 KAR 1:370 and this administrative regulation. (e) The medical director may be the program physician. (3) NTPs shall provide dosing staff in sufficient numbers to meet the needs of the clients during dosing hours. Dosing staff shall: (a) Hold a license as a registered nurse, licensed practical nurse, or pharmacist; and (b) Not be dually assigned as counselors.	

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			(c) Dosing physicians and pharmacists shall follow KRS 218A.180 related to labeling if preparing doses to be taken outside the program site. (4) Programs shall provide counselors who shall have, at a minimum, a bachelor's degree in a human services related field and an alcohol and drug counselor certification from the Kentucky Board of Alcohol and Drug Counselors or be actively engaged in the certification process. **KAR 908:340**	
3	Staffing Requirements	**DATA 2000, as amended in December 2006**, specifies that an individual physician may have a maximum of 30 patients on opioid therapy at any one time for the first year. One year after the date on which a physician submitted the initial notification, the physician may submit a second notification of the need and intent to treat up to 100 patients For the OTPs: • There shall be one (1) medical director or program physician on staff for every 300 clients, or fraction thereof, enrolled in a NTP. • There shall be one (1) counselor for every forty (40)		Includes caseload size, team composition, training and continuing education requirements, etc.

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		clients in the program **KAR 908.340** Training should be offered for all staff members, including secretaries, nurses, counselors, supervisors, and managers, to ensure a strong knowledge base so that staff members do their best and to affirm that all staff members are valued members of the treatment team. The importance of training has increased because accreditation standards require OTPs to provide continuing staff education, with many States requiring such education for OTPs to maintain licensure. OTPs should help professional staff members acquire education credits to maintain their licensure by offering onsite training, collaborating with other agencies for reciprocal training, or paying for educational leave or tuition. At minimum, training should focus on the following areas: •Facts about MAT and the health effects of treatment medications. Educating OTP staff about the health effects of MAT medications and the value of remaining in treatment is essential. Some studies have revealed a high level of misinformation among OTP staff members about the health effects of maintenance medications (e.g., Kang et al. 1997). Other studies have shown that many staff members hold negative attitudes about MAT (e.g., Caplehorn et al. 1997), which negatively affect patient outcomes (Caplehorn et al. 1998). One way to address negative staff attitudes is to include successful patients in training (Bell 2000). •Up-to-date information about medications. Staff should be able		

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		to discuss medications with patients. Medical staff members should be able to assess patients and determine, with input from other treatment team members, which medication is most appropriate. •Up-to-date information about drugs of abuse . Training should ensure that staff members are knowledgeable about drug abuse trends in the community. •Up-to-date information about communicable diseases. Training should focus on both diseases commonly experienced by patients in MAT, such as hepatitis C, and emerging diseases in the community, possibly including tuberculosis or HIV/AIDS. •Skills training. Staff members should have access to generic skills training such as crisis management, communications, and problem solving, as well as new evidence-based MAT treatments. They should have access to training about the populations the OTP serves, including cultural information and information about specific disorders. •Patient sensitivity training. The importance of emphasizing sensitivity to patient needs should be reviewed periodically. No matter how creative and naturally sensitive a staff member may be, factors such as burnout can affect how he or she responds. **(TIP 43)**		
4	Supervision Requirements			
5	Admission Criteria	**Patient admission criteria—**	**FOR PREGNANT CLIENTS**	

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		(1) Maintenance treatment. An OTP shall maintain current procedures designed to ensure that patients are admitted to maintenance treatment by qualified personnel who have determined, using accepted medical criteria such as those listed in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), that the person is currently addicted to an opioid drug, and that the person became addicted at least 1 year before admission for treatment. In addition, a program physician shall ensure that each patient voluntarily chooses maintenance treatment and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient, and that each patient provides informed written consent to treatment. (2) Maintenance treatment for persons under age 18. A person under 18 years of age is required to have had two documented unsuccessful attempts at short-term detoxification or drug-free treatment within a 12-month period to be eligible for maintenance treatment. No person under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant State authority consents in writing to such treatment. (3) Maintenance treatment admission exceptions. If clinically appropriate, the program physician may waive the requirement of a 1-year history of addiction under paragraph (e)(1) of this section, for patients released from penal institutions (within 6 months after release), for pregnant patients (program physician must certify pregnancy), and for previously treated patients (up to 2 years after discharge).	Exceptions to the admission requirements shall be those cited in 42 C.F.R. Part 8. Programs shall adhere to the following for pregnant clients: In order for a NTP to admit or continue to treat a client who is pregnant the medical director or program physician shall first determine and document in the client's record the following: (a) The client is medically able to participate in the program. (b) If the medical director or program physician does not accept the responsibility for providing prenatal care for the term of the client's pregnancy, the medical director or program physician shall refer the client to a primary care physician who practices obstetrics or an obstetrician and shall inform the attending physician of the client's participation in the NTP. (c) If a pregnant client, the medical director or program physician shall ensure that	

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		(42 CFR 8.12)	appropriate arrangements have been made for the addiction-related medical care of both the client and the child following the birth of the child. (d) Maintenance treatment dosage levels of pregnant clients shall be maintained at the lowest possible dosage level. (e) The program shall ensure that the following services are available for pregnant addicts and are a part of the treatment plan: 1. The medical director or program physician shall notify the pregnant client's primary care physician of any changes in the client's treatment; 2. Nutritional counseling; 3. Parenting training including newborn care, handling, health, and safety; and 4. Weekly full drug screen urinalysis; **KAR 908:340**	

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6	Service Planning / Documentation	(g) Recordkeeping and patient confidentiality. (1) OTPs shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. This system is required to comply with all Federal and State reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction. All records are required to be kept confidential in accordance with all applicable Federal and State requirements. (2) OTPs shall include, as an essential part of the recordkeeping system, documentation in each patient's record that the OTP made a good faith effort to review whether or not the patient is enrolled any other OTP. A patient enrolled in an OTP shall not be permitted to obtain treatment in any other OTP except in exceptional circumstances. If the medical director or program physician of the OTP in which the patient is enrolled determines that such exceptional circumstances exist, the patient may be granted permission to seek treatment at another OTP, provided the justification for finding exceptional circumstances is noted in the patient's record both at the OTP in which the patient is enrolled and at the OTP that will provide the treatment**. (42. CFR 8.12)** **ASSESSMENT:** STANDARD I.1: Comprehensive Assessment The addiction specialist physician assures that an initial comprehensive, multicomponent assessment is performed for each patient, either by performing it her/ himself or by assuring it is conducted in full or in part by another qualified professional within the system in which she/he is working. The addiction specialist physician assures that, for every patient under his or	There shall be documentation in the client record that treatment plans shall be reviewed and updated a minimum of every thirty (30) days for three (3) months, every ninety (90) days thereafter. Documentation of the justification for continued maintenance treatment required by this administrative regulation shall indicate the client's progress, or lack thereof, and future expectations as required by this administrative regulation (**KAR 908:340)** STANDARD III.6: Documenting Clinical Decisions The addiction specialist physician assures that the reasoning behind clinical decision-making is documented within the treatment plan in the patient's health record. Documentation in the patient's health record by the addiction specialist physician or another member of the treatment team should reflect knowledge of the patient, include options discussed and	Goals of Assessment The goals of the medical assessment of a patient who is addicted to opioids are to •Establish the diagnosis or diagnoses •Determine appropriateness for treatment •Make initial treatment recommendations •Formulate an initial treatment plan •Plan for engagement in psychosocial treatment •Ensure that there are no contraindications to the recommended treatments •Assess other medical problems or conditions that need to be addressed during early treatment •Assess other psychiatric or psychosocial problems that need to be addressed during early treatment Components of Assessment The components of the assessment of a patient who is addicted to opioids should include

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		her care, the assessment is reviewed and updated on a regular basis, including at every care transition, to promote treatment engagement and meet the patient's needs and preferences. A comprehensive assessment for a person with addiction includes the following components: • A physical exam • Medical and psychiatric history • A detailed past and present substance use history, including assessment of withdrawal potential • A history of the pathological pursuit of reward or relief through engagement in addictive behaviors, such as gambling or excessive food or alcohol intake. Substance use disorder and addictive disorder treatment history and response to previous treatment, including history of use of pharmacotherapies and response to such interventions • Family medical, psychiatric, substance use, addictive behavior and addiction treatment history • Allergies • Current medications • Social history • Consultation with appropriate collateral sources of information • A summary of the patient's readiness to engage in treatment, potential to continue unhealthy use or return to unhealthy engagement in substance use or addictive behaviors, and the recovery environment that can support or impede recovery	patient preferences, set out a mutually agreed-upon plan of action to accommodate the individual needs of the patient, as well as delineate measureable goals of treatment. **(Standards of Care for the Addiction Specialist Physician 2014)** The program shall ensure that the following services are available for pregnant addicts and are a part of the treatment plan: 1. The medical director or program physician shall notify the pregnant client's primary care physician of any changes in the client's treatment; 2. Nutritional counseling; 3. Parenting training including newborn care, handling, health, and safety; and 4. Weekly full drug screen urinalysis;	• Complete history • Physical examination • Mental status examination • Relevant laboratory testing • Formal psychiatric assessment (if indicated) In forming a framework for assessment, physicians may include questions and evaluations pertinent to the most recent edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) and the categories of the Addiction Severity Index (ASI) (Mee-Lee 2001; McLellan et al. 1992). The ASAM PPC may be ordered from ASAM at http://www.asam.org. The full text of the ASI can be downloaded from the Treatment Research Institute Web site at http://www.tresearch.org.

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		• Diagnostic formulation(s) • Identification of facilitators and barriers to treatment engagement including patient motivational level and recovery environment **(Standards of Care for the Addiction Specialist Physician 2014)** **ASSERTIVE OUTREACH AND ENGAGEMENT:** Community Relations and Education Plan Each OTP should develop a community relations and education plan that extends from its general mission statement. Staff and patients should be part of a multifaceted, proactive effort to educate community entities affected by OTP operations, including the medical community, neighbors, and agencies and individuals providing support services. Although program activities differ in specificity and scope, a community relations plan should address the following: •Learning about the community, its structures, and directly affected constituents •Delineating the community relations mission, goals, protocols, and staff roles •Initiating and maintaining contact with community liaisons •Educating and serving the community •Establishing effective media relations •Developing policies and procedures to address community concerns about the OTP •Documenting community contacts and community relations activities. **(TIP 43)**	**KAR 908:340**	

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		WORKING WITH NATURAL SUPPORTS: STANDARD III.5: Involving Social Support Networks The addiction specialist physician assures that attempts are made to involve social networks and the people Therein are in the treatment process. For example, the addiction specialist physician assures that appropriate support services are made available for patients' families. **(Standards of Care for the Addiction Specialist Physician 2014)** (5) Counseling services. (i) OTPs must provide adequate substance abuse counseling to each patient as clinically necessary. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate treatment plan for the patient and to monitor patient progress. (ii) OTPs must provide counseling on preventing exposure to, and the transmission of, human immunodeficiency virus (HIV) disease for each patient admitted or readmitted to maintenance or detoxification treatment. (iii) OTPs must provide directly, or through referral to adequate and reasonably accessible community resources, vocational rehabilitation, education, and employment services for patients who either request such services or who have been determined by the program staff to be in need of such services. **(42.CFR 8.12)**		
7	Continued Stay			

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	Criteria			
8	Discharge Criteria		STANDARD V.2: Assuring Quality in Transitions The addiction specialist physician assures that transitions between levels of care for substance use disorders are informed by a biopsychosocial evaluation, patient preferences, and the patient's history of responses to previous attempts at treatment. STANDARD VI.1: Assuring Continuity in Addiction Care The addiction specialist physician encourages patients to meet with him or herself or with a designated care provider who intermittently monitors and assesses the patient's maintenance of recovery. The addiction specialist physician's or other care provider's assessment for continuing care management can	

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			include the following: • Patient and collateral interview • Physical and/or psychological examination as appropriate • Structured rating scales • Review of current medications • Laboratory studies • Engagement in recovery activities STANDARD V.4: Providing Referral When patients transition from a given level of care, terminate addiction treatment, or terminate with a specific addiction provider, the addiction specialist physician provides recommendations and referrals for continuing professional care and/or self-management. The addiction specialist physician assures that the community and medical resources available to the patient, including the resources available through the patient's primary care provider or medical home, have been identified in a way that	

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			maximizes the patient's sustained functional recovery and is aligned with the patient's goals. **(Standards of Care for the Addiction Specialist Physician 2014)**	
9	Service Setting	Services may be provided in an Opioid Treatment Program (OTP), a medication unit affiliated with an OTP, or, with the exception of Methadone, a physician's office or other community based setting including the recipient's home/residence, homeless shelter, school (only if not an IEP covered service), or other community setting where the recipient may wish/need to receive a service.	Must be licensed per 908:340. For medication other than Methadone, they must adhere to SAMSHA regulations for Suboxone treatment for doctors currently that are in place is have to have Drug Addiction Treatment ACT **(DATA) 2000 certification ---*(DEA)**	There is the possibility of the OBOT (Office Based Opioid Treatment) License regulation being put in place. Strongly recommend we utilize this. Documentation must include service site.
10	Service Limitations / Exclusion	Methadone can only be in a licensed Opioid Treatment Program. MATs are non-residential and must comply with all state laws.	Once a physician obtains the DATA 2000 waiver, he or she may treat up to 30 patients for narcotic addiction with buprenorphine. Recent changes to DATA 2000 have increased the patient limit to 100 for physicians that have had their waiver for a year or more and request the higher limit in writing.	The state plan lists these components- Service components include: • Individual and Group therapy • Dosing • Medication • Assessment and • Drug screens
11	Unit of Service		Per diem	
12	Service Codes			
13	Program Evaluation / Quality Improvement	KORTOS CDAR.uky.edu/KORTOS		
14	Program Principles			

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