

02	DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
373	BOARD OF LICENSURE IN MEDICINE
380	STATE BOARD OF NURSING
383	BOARD OF OSTEOPATHIC LICENSURE
Chapter 12:	JOINT RULE REGARDING OFFICE BASED TREATMENT OF OPIOID USE DISORDER

Summary: Chapter 12 is a joint rule of the Board of Licensure in Medicine, the State Board of Nursing, and the Board of Osteopathic Licensure to ensure safe and adequate treatment of opioid use disorder with Approved Medications in an outpatient medical setting that is not a certified Opioid Treatment Program.

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SECTION 1. DEFINITIONS

1. **Administrative Discharge** means the involuntary process of medically supervised withdrawal from medications for Opioid Use Disorder.
2. **Approved Medications** means medications that are FDA approved for the treatment of Opioid Use Disorder (OUD) in an office based setting that is not a certified Opioid Treatment Program (OTP).
3. **ASAM** means the American Society of Addiction Medicine.
4. **Board** means the Board of Licensure in Medicine, the State Board of Nursing, and the Board of Osteopathic Licensure.
5. **Clinical Discharge** means the voluntary process, agreed upon by both the patient and provider, of medically-supervised withdrawal by gradually tapering medication for ultimate cessation of therapy.
6. **Clinician** means a Maine-licensed physician, physician assistant, or advanced practice registered nurse.

7. **Co-occurring Disorder** means an individual who has a co-existing mental illness and a substance use disorder.
8. **DEA** means the Drug Enforcement Administration in the U.S. Department of Justice.
9. **Drug Diversion** means the transfer of a controlled substance from authorized legal and medically necessary use or possession to illegal and unauthorized use or possession.
10. **FDA** means the U.S. Food and Drug Administration.
11. **Informed Consent** means written agreement by a patient to a medical procedure, or for participation in OBOT, after achieving an understanding of the relevant medical facts, risks and benefits, and alternative treatments.
12. **Medical Emergency** means an acute injury or illness that poses an immediate risk to a person's life or long-term health.
13. **Misuse** means all uses of a prescription medication other than those that are directed by a clinician in accordance with the plan of treatment.
14. **Office Based Opioid Treatment (OBOT)** means providing medication and other non-pharmacologic modalities to treat OUD in outpatient medical settings other than certified OTPs.
15. **Opioid Treatment Program (OTP)** - (sometimes referred to as a "methadone clinic" or "narcotic treatment program") means any treatment program certified by SAMHSA in conformance with 42 Code of Federal Regulations (CFR), Part 8, to provide supervised assessment and medication assisted treatment of patients with OUD. **Only federally certified and accredited OTPs may prescribe and/or dispense methadone for the treatment of OUD.**
16. **Opioid Use Disorder (OUD)** means the criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders for OUD.
17. **Outpatient** means a health care setting where the patient is not admitted to a hospital, skilled nursing facility or long-term care facility.
18. **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.
19. **Recovery** means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
20. **SAMHSA** means the federal Substance Abuse and Mental Health Services Administration.
21. **Telehealth** means the provision of health care services using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a clinician in one location and a patient in another location with or without an intervening health care provider. Telehealth includes asynchronous store-and-forward technologies, telemonitoring, and

real-time interactive services, including teleradiology and telepathology. When necessary and appropriate under the circumstances and if in compliance with the applicable standard of care, telehealth includes the use of audio-only technology. Telehealth shall not include the provision of health care services between a licensee in one location and a patient in another location with or without an intervening health care provider only through e-mail, instant messaging, facsimile transmission, or U.S. mail or other parcel service, or any combination thereof.

22. **Toxicology Tests** means any laboratory analysis for the purpose of detecting the presence of alcohol and/or various scheduled or illicit drugs.

SECTION 2. PURPOSE

The Board is obligated under the laws of the State of Maine to protect the public health and safety. The Board recognizes that medical and advanced nursing practice dictate that the people of the State of Maine have access to appropriate, empathetic and effective treatment of opioid use disorder (OUD). This rule establishes minimum requirements for qualified Office Based Opioid Treatment (OBOT) clinicians to prescribe, and in limited circumstances, dispense approved medications to individuals requiring and seeking treatment for OUD.

The Board recognizes the body of evidence regarding the effectiveness of Approved Medications in the office based treatment of OUD, when such treatment is delivered in accordance with current standards of care, the requirements of federal laws and regulations, and this joint rule. Overdoses and deaths due to approved medications can occur and have been reported. Most overdoses, especially fatal ones, involve the concurrent use of another central nervous system (CNS) depressant such as benzodiazepines, other opioids, or alcohol. Approved Medications such as buprenorphine also pose a significant risk to non-tolerant individuals, especially children. The goal is to provide appropriate treatment of the patient's OUD (either directly or through referral), while adequately addressing other aspects of the patient's functioning including co-occurring medical and psychiatric conditions and psychosocial issues.

The Board also recognizes the importance of appropriate training and education for clinicians providing OBOT. Clinicians providing OBOT are strongly encouraged to complete continuing education in OBOT and to review the published guidelines of SAMHSA and ASAM that are referenced in this rule, as the Board may use these guidelines, as well as other sources and outside expert reviews, as the standard of care when evaluating OBOT provided by clinicians.

The Board will evaluate allegations of inappropriate OBOT by referring to the rules, current clinical practice guidelines, and standards of care. Clinicians should not fear disciplinary action by the Board for providing OBOT if they are following standards of care, established guidelines and the requirements of this rule. Judgment regarding the propriety of any specific course of action must be based on all of the circumstances presented, and thoroughly documented in the patient's medical record.

SECTION 3. QUALIFICATIONS

1. Clinicians who wish to provide Approved Medications for OUD in an OBOT must:
 - A. Hold a current license issued by the Board;

- B. Hold a current controlled substance registration issued by the DEA;
 - C. Complete buprenorphine training in accordance with applicable State and federal laws, rules, and regulations;
 - D. When required by State law, physician assistants must work in collaboration with a licensed physician when prescribing medications for the treatment of opioid use disorder; and
 - E. Comply with this joint rule.
2. Patient limits. Clinicians must be aware of and comply with limits, if any, established by the DEA regarding the number of patients that can be treated with Approved Medications in OBOT.

SECTION 4. PRESCRIPTION REQUIREMENTS

Prescriptions for Approved Medications to treat OUD must include:

1. The full identifying information for the patient, including the patient's name and address;
2. The drug name, strength, dosage form, and quantity;
3. Directions for use;
4. The date on which the prescription is signed, which must be the same day it is issued;
5. If the date the medication is to be filled is different from the date it is written, it must be indicated on the prescription;
6. The clinician's DEA registration number;
7. The appropriate ICD code; and
8. The specific DHHS exemption code for dosage limits (if applicable).

SECTION 5. PRINCIPLES OF PROPER OBOT

1. **Develop and Maintain Competency**
 - A. The diagnosis and medical management of OUD should be based on current knowledge and research, and should encompass the use of both pharmacologic and nonpharmacologic treatment modalities. Thus, before beginning to treat patients for opioid addiction, clinicians must be knowledgeable about OUD and its treatment, including the use of approved pharmacologic therapies and evidence-based nonpharmacologic therapies. Clinicians should consult the DEA regulations and the resources available on the DEA's website. Clinicians are encouraged to complete continuing education in OBOT and to access the following published guidelines on the use of medications for OUD:

1. SAMHSA - TIP 63 - Medication for Opioid Use Disorder; and
2. ASAM National Practice Guidelines For the Use of Medications in the Treatment of Addiction Involving Opioid Use.

2. **OBOT Administration and Operations Requirements**

OBOT clinicians shall ensure that all OBOT medical settings have and maintain all of the following in order to initiate and continue prescribing Approved Medications:

- A. Sufficient space and adequate equipment to provide appropriate patient care and monitoring, including but not limited to ensuring:
 1. Security and privacy for the collection of toxicology samples if samples are to be collected on site;
 2. Clean and well maintained environment;
 3. Areas where privacy and confidentiality can be maintained; and
 4. Protection of all confidential medical information and records in hard copy or electronic formats.
- B. Referral arrangements with other clinicians and practitioners to evaluate and treat medical comorbidities and co-occurring disorders to ensure that OBOT is provided in the context of other health issues the patient may have.

3. **Clinician Absence and Closure Preparedness**

A. **Continuity of OBOT Services for Clinician Absence**

Each OBOT clinician shall develop and maintain a written plan for the administration of Approved Medications to treat established OUD patients in the event of an absence. The plan should include:

1. Informing patients of alternate care; and
2. Emergency procedures for obtaining prescriptions/access to medications in case of temporary program/office closure. This should include an agreement with another clinician authorized to prescribe Approved Medications or with an OTP. It should also include the ability to transfer or provide access to patient records.

B. **Permanent OBOT Program Closure**

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

1. Orderly and timely transfer of patients and records to another OBOT clinician; and
2. Notifying patients of transition plans.

4. **Clinical Care and Management Requirements**

A. **Diagnosis of OUD and Acceptance for OBOT**

When commencing OBOT, and in addition to ensuring that any patient has an appropriate medical evaluation as described below in this rule, the OBOT clinician shall assess the patient and diagnose and document an OUD as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

B. **Evaluation of the Patient's Health Status**

1. **Medical Evaluation**

When commencing OBOT, the OBOT clinician shall conduct an appropriate medical, social, and family history, physical examination and necessary laboratory tests (including pregnancy testing when appropriate), or refer the patient to a medical professional who can perform such an evaluation. Identification of signs and symptoms of opioid use and/or withdrawal, comorbid medical and co-occurring psychologic conditions, and how they will be addressed, should be a goal of the medical evaluation. Long-term management is effective for many chronic diseases, including OUD.

2. **Psychosocial Assessment and Referral to Services**

- a. OBOT clinicians shall conduct a psychosocial assessment, or shall refer the patient for such an assessment to another clinician qualified by education, training or experience, or to a licensed mental health provider, before or as soon as possible after the initiation of the OBOT.
- b. Based on the outcomes of the psychosocial assessment, the OBOT clinician may recommend to the patient that the patient should participate in ongoing counseling or other behavioral interventions such as recovery programs. Patients should be advised to receive counseling from OBOT clinicians or other qualified licensed providers.
- c. An OBOT clinician should employ appropriate clinical judgment in deciding whether to deny or discontinue OBOT based solely on a patient's decision not to follow a recommendation to seek counseling or other behavioral interventions.

C. **Developing an OBOT Plan**

1. Individuals who are identified by OBOT clinicians as having higher

needs for care (e.g. ASAM level 2 or higher), or needing more clinical oversight or structure than available through an OBOT, shall be referred to an appropriate OTP or other more intensive level of care (e.g. inpatient).

2. OBOT clinicians shall register with the Maine Prescription Monitoring Program (MPMP) and comply with Maine's laws and rules regarding reporting on dispensed controlled substances. OBOT clinicians shall check the MPMP prior to initiating OBOT and at least every ninety days thereafter or more frequently when clinically indicated.
3. OBOT clinicians shall adhere to all applicable standards of medical practice for providing treatment.

D. Informed Consent, Patient Treatment Agreement, Releases

Unless unable to do so as a result of a genuine "medical emergency" as defined in Section 1 of this rule, prior to providing OBOT, an OBOT clinician shall:

1. Obtain and document voluntary Informed Consent to treatment from each patient, which shall include the known risks and benefits of the medication being prescribed.
2. Establish a written treatment agreement outlining the responsibilities and expectations of the OBOT clinician and the patient, which shall include possible reasons for discharge from the practice.
3. Provide OUD patients with education regarding the prevention of opioid overdose. In addition, OBOT clinicians should consider prescribing overdose rescue medications (e.g. naloxone) for all OUD patients.
4. 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.

E. Ongoing Patient Treatment and Monitoring

In addition to following standard clinical practices, OBOT clinicians must adhere to the following provisions:

1. Monitoring for Diversion

To ensure patient and public safety, each OBOT clinician shall develop a written policy outlining their clinical practices to minimize risk of diversion of medications to treat OUD. The frequency of monitoring procedures is based on the unique clinical treatment plan for each patient and the patient's level of stability. At a minimum, this plan shall include the following practices:

- a. Querying the MPMP;

- b. Informing OBOT patients that diversion is a criminal offense;
- c. Conducting toxicological tests;
- d. Conducting medication counts;
- e. For patients receiving services from multiple providers, the coordination of care and sharing of toxicology test results is encouraged;
- f. Collecting all toxicological specimens with a standardized protocol and in a therapeutic context; and
- g. Addressing and documenting the unexpected results of toxicological tests promptly with patients.

2. **Education and Rescue Medications**

OBOT clinicians shall provide OUD patients with education regarding the prevention of opioid overdose. In addition, OBOT clinicians should consider prescribing overdose rescue medications (e.g. naloxone) for all OUD patients.

5. **Administrative Discharge from OBOT**

A. Appropriate administrative discharge from OBOT does not constitute patient abandonment. OBOT clinicians may opt to discontinue prescribing medications for OUD and involuntarily discharge patients from their OBOT in the following situations:

- 1. Disruptive behavior that has an adverse effect on the OBOT practice, staff or other patients. This includes, but is not limited to:
 - a. Violence;
 - b. Aggression;
 - c. Threats of violence;
 - d. Drug diversion;
 - e. Trafficking of illicit or prescription drugs;
 - f. Repeated loitering in or near the OBOT facility; and
 - g. Conduct resulting in an observable, negative impact on the patient, and/or staff and/or other patients.
- 2. Incarceration or other relevant change of circumstance. However, if the incarceration follows criminal conduct that occurred prior to OBOT, then resumption of OBOT following incarceration is encouraged if clinically

indicated.

3. Violation of or noncompliance with the treatment agreement.
 4. Nonpayment of fees.
- B. When an OBOT clinician or practice decides to administratively discharge an OBOT patient, the clinician must manage the appropriate tapering of buprenorphine or other medication, when it is clinically appropriate, and as long as it does not compromise the safety of patients, clinicians or program staff.
 - C. A patient who is involuntarily discharged from OBOT should be provided referral information for other OBOT clinicians, OTPs, or other OUD treatment programs. OBOT clinicians shall document referral efforts in the patient's medical record.
 - D. Factors contributing to the involuntary discharge from the program shall be documented in the patient's medical record.

6. **Patient Records**

OBOT clinicians shall keep accurate and complete patient records , with emphasis on documentation of and the patient's response to treatment. Information that shall be maintained in the patient record includes:

- A. Copies of signed informed consent and treatment agreement;
- B. The patient's medical history and any records from prior providers;
- C. Documentation of MPMP queries and their effect on treatment;
- D. Results of the physical examination, laboratory tests, and toxicological tests;
- E. Treatment plan;
- F. A description of the treatments provided, including all medications prescribed or administered (including the date, type, dose, frequency and quantity);
- G. Results of ongoing monitoring of patient progress (or lack of progress);
- H. Notes on evaluations by and consultations with specialists; and
- I. Other medical decision making to support the initiation, continuation, revision, or termination of treatment, and the steps taken in response to any abnormal toxicological test results or aberrant medication use behaviors.

7. **Reportable Acts**

Generally, information gained as part of the clinician/patient relationship remains confidential. However, the clinician has an obligation to deal with persons who use the clinician to perpetrate illegal acts, such as illegal acquisition or selling of drugs; this may

include reporting to law enforcement. Information suggesting inappropriate or drug-seeking behavior should be addressed appropriately and documented. Use of the MPMP is mandatory in this situation.

8. **Additional Requirements for Special Populations**

A. **Pregnant Patients:**

The decision to treat a pregnant patient with buprenorphine or to refer her to an OTP for methadone is one that should be made in conjunction with the patient. Due to the risks of opioid addiction to pregnant women and their fetuses, a pregnant woman seeking OBOT should be given priority for treatment, and every effort should be made for evaluation and treatment as soon as possible. Because of the high risk to the fetus, every effort should be made to maintain pregnant women on medications for OUD during pregnancy. If there is a compelling reason for involuntarily withdrawing a pregnant woman from OUD medications for reasons specified in this rule, the clinician shall refer the woman to the most appropriate obstetric care available and an alternative provider for OUD treatment as soon as possible.

B. **Adolescent Patients:**

OBOT clinicians who do not specialize in the treatment of adolescent OUD should strongly consider consulting with or referring adolescent patients to a more qualified clinician, if available.

C. **Patients with Co-occurring Disorders:**

OBOT clinicians should be aware of potential interactions between medications used to treat co-occurring psychiatric conditions and OUD.

All patients with psychiatric disorders should be asked about suicidal ideation and/or attempts behavior. Patients with a history of suicidal ideation or attempts should have OUD and psychiatric medication use closely monitored. OBOT clinicians should consider referral to a mental health clinician, if available.

SECTION 6. Telehealth Practice

1. Telehealth is a useful tool that, if applied appropriately, can provide important benefits to patients, including increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and potential cost savings.
2. Clinicians using telehealth in providing health care will be held to the same standards of care and professional ethics as clinicians providing traditional in-person health care.
3. Failure to conform to the appropriate standards of care or professional ethics while using telehealth in providing health care may subject the clinician to potential discipline by the Board.
4. Clinicians shall follow all applicable rules regarding Telehealth, including the Chapter 11 Joint Rule Regarding Telehealth Standards of Practice.

STATUTORY AUTHORITY:

32 M.R.S. §§ 3269(3),(7), 3300-EE, 3300-F; (Board of Licensure in Medicine)

32 M.R.S. §§ 2102(2-A), 2153-A(1), 2210, 2270; (State Board of Nursing)

32 M.R.S. §§ 2562, 2600-C, 2600-EE; (Board of Osteopathic Licensure)

EFFECTIVE DATE:

April 29, 2020 – filings 2020-107, 108, 109

AMENDED:

July 24, 2022 – filings 2022-142, 143, 144

February 26, 2024 – filings 2024-036, -037, -038