# Frequently Asked Questions
## For Emergency Part 828
## Opioid Treatment Program Regulations

Effective Monday February 8, 2010 OASAS adopted the new NYS OASAS Part 828 Opioid Treatment Program regulations. Since the emergency adoption of the new Part 828 regulations, OASAS has received numerous inquiries from OTPs requesting clarification of the new emergency Part 828. The purpose of this Frequently Asked Questions document is to share with all OTPs the questions asked and answers provided to OTPs. The answers are intended to provide clarification to the new Part 828 regulations to assist OTPs in the implementation of the new regulations.

Please note that OASAS will be pursuing regulatory changes identified in this document during a formal full rule making process which will include a formal public comment period. This full rule making will be part of the OASAS revisions to our Part 822 Outpatient regulations which will result in the Opioid Treatment Program regulations being merged with the other outpatient regulations into one comprehensive regulation.

### Definitions (828.4)

1. Q. 828.4 (m) the definition for Opioid Detoxification states not to exceed 4 weeks. Can an OTP provide long-term detoxification treatment?

A. OTPs with a long-term detoxification treatment protocol should submit a waiver request with supporting documentation to the waiver committee.

### Additional location (828.5)

2. Q. How do I apply for an additional location?

A. Applications for an additional location for Part 828 OTPs are not being processed at this time.

### Screening for admission & Admission procedures (828.7 & 828.8)

3. Q. 828.7 (h) applicants with a chronic immune deficiency condition shall be screened and admitted on a priority basis. How do we make that determination if past records are not received within 72 hours?

A. All applicants to OTPs must be screened for admission through face-to-face contact and admitted within 72 hours, if regulatory admission criteria are met and the OTP is below certified capacity. Admissions are based on the OTPs own medical and clinical evaluation. No records from any entity are required to admit an applicant to treatment, i.e., the non-receipt of a record

cannot prevent an admission. If at certified capacity, the OTP must maintain and use a waiting list of otherwise acceptable applicants.
Applicants who are pregnant or with a chronic immune deficiency are deemed priority applicants. OTPs place priority applicants at the head of any waiting list and give such applicants the opportunity to be admitted before anyone on the list. The priority is determined as best as possible by patient's history and physical evaluation.

4. Q. In Section 828.8 (a) Admission Procedures it states each person admitted to an OTP shall be evaluated within 24 hours but no longer than 72 hours when necessary. What type of evaluation is this referring to?

A. The intention of 828.8 (a) is a patient must be screened for admission through face-to-face contact and admitted and medicated within 24 hours but no longer than 72 hours when necessary. This is not referring to the comprehensive physical exam which must be conducted within the first week.

5. Q. The new regulations indicate that a physical evaluation must be performed by a physician 828.7(d). A subsequent section 828.8(e) (4) states that a prescribing professional must complete a physical examination - does this mean all admissions must see a physician prior to admission?

A. Yes. It is the expectation that the physician sees all patients face-to-face as part of the admission. Admitting the patient to maintenance or detoxification treatment must be done by a physician. This cannot be deferred under any circumstance. In an emergency, a physician can be provided with the results of a physical evaluation by a qualified health care provider, by phone or fax, and the physician can admit the patient over the phone based upon that assessment. The patient record must be signed by the program physician within 72 hours.

Evaluation and comprehensive physical examination are not referring to the same requirement. 828.7 (d) refers to a physical **evaluation** prior to admission. The evaluation is necessary to make the determination of addiction by a physician. **Evaluation** is defined as the verification of addiction prior to admission. The physician must diagnose addiction or dependence, document that diagnosis, and admit each patient to maintenance. 828.8 (e) (4) refers to a comprehensive physical **examination**. The comprehensive physical examination includes other medical conditions which may be conducted by a prescribing professional. **Examination** is defined as the full physical examination, post admission, including results of serotology and other test results. The examination should cover all major organs and the patient's overall health status.

6. Q. In section 828.8 (d) it states "a physician must substantiate the determination of a history of opioid dependence and current physical dependence". Does this have to be done by a physician?

A. Yes. Determination is the decision to admit a patient to opioid treatment which must be done by a physician.

7. Q. In 828.8 (e) (2) Admission Procedures it states staff must obtain medical, addiction, and mental health information in the development of the comprehensive treatment plan within two weeks of admission. 828.9 (d) states that a comprehensive individualized patient centered treatment plan is due within 30 days of admission. When is the psychosocial and comprehensive treatment plan due?

A. The term “complete, narrative psychosocial history” found in the old regulations has been replaced with “obtain medical, addiction and mental health information”. As written, the regulations require OTPs to obtain the medical, addiction and mental health information that will be used in the development of the treatment plan within two weeks of admission and the completed comprehensive treatment plan is due within 30 days.

8. Q. Under section 828.8 (e) (5) required laboratory tests it states (vi) Hepatitis A, B or C. Is it really “or” instead of “and”? Can an OTP test only for Hepatitis C?

A. The regulations purposely states “or” to allow a prescribing professional to use good clinical judgment. For example, if a patient gives a history of Hepatitis B or vaccination with Twinrix, then really only Hepatitis C is indicated.

9. Q. 828.8 (e) (6) tests for sexually-transmitted diseases should be completed as necessary. Does this mean that a test for syphilis is no longer required?

A. Yes.

10. Q. The reference for the annual exam now says: 828.8 (f) A prescribing professional must annually repeat the physical examination required at admission. A patient can choose to have a non-OTP licensed practitioner complete the annual physical examination to determine health condition with all required results, including ordered tests, recorded in the patient’s chart. Does this mean that annual lab work and/or a ppd are still required?

A. Yes “all required results” includes annual lab work and/or a ppd. A patient must receive an annual physical either at the OTP or if the patient chooses from a non-OTP licensed practitioner who includes all medically indicated lab work.

11. Q. What date does an OTP use to complete required documentation, such as annual physicals and quarterly treatment plans, when an OTP accepts a transfer patient from another OTP -- is it the "admission" date of the sending OTP or the "transfer" date of the receiving OTP [Parts 828.8(k)(4) and 828.9(f)].

A. The "admission" date of the sending OTP is the official date to use for all required documentation when a patient is transferred from one OTP to another, whether within New York State, from another state, or within a provider's own system of multiple sites. For example, if Program A admits a patient on January 1st and transfers that patient to Program B on May 1st, the patient's annual physical is due every January 1st, while the patient's quarterly treatment plan is due April, June, September, and December. Unfortunately, the date confusion is usually caused by either terminology or administrative systems. Clarity occurs when when treatment continuity is kept foremost in mind. To extend the above example, Program B need not complete an "admission" physical on May 1st -- as many OTPs do in practice -- as no actual admission occurred in the continuous treatment of the patient.

OTPs should determine whether a transfer is temporary or permanent prior to receiving the patient from the sending OTP.

12. Q. 828.8 (l) (6) regarding billing for patients in temporary treatment. Medicaid billing is on a weekly basis and is a flat rate for the week. Frequently patients are being guest medicated temporarily in another program for only part of the week, and in the home program for

the rest of the week. Since Medicaid cannot be billed for a partial week, which OTP can bill the sending or receiving OTP?

A. The regulation as written is incorrect. The regulation should state:

"6) the sending OTP cannot bill Medicaid for non-threshold visits nor collect fees from self-pay patients during the temporary treatment period."

Pursuant to Medicaid law and a long established Medicaid policy in our State, an OTP program can only bill for services provided to an admitted patient. The billing consists of a weekly methadone fee which is reimbursement for all the services a patient is supposed to get from the program during the week. If OTP A temporarily transfers a patient to OTP B for a few days, OTP A can bill Medicaid if the patient made a threshold visit to OTP A that week. OTP B can not bill Medicaid because the patient is not admitted to OTP B.

**Individual treatment (828.9) & Recordkeeping (828.10)**

13. Q. It states in 828.9 (c) that all patients must have an individual session at least once a month. Is this correct? We have a counseling policy but time frames are determined by patient need and circumstances not set by time in treatment.

A. The regulation states that individualized treatment includes one individual counseling session each month. OTPs with a counseling policy that differs from this regulation may submit a waiver request with supporting documentation to the waiver committee.

14. Q. 828.9 (f): Does the "summary of the patient's progress in each of the specified treatment plan goals" need to be part of the treatment plan or could this be covered in a progress note?

A. No. The summary must be documented in the treatment plan review which is separate from the comprehensive treatment plan and not a progress note.

15. Q. What do you do with a patient who is not responding to treatment [828.9 (i)]?

A. The phrase "not responding to treatment" generally refers to documentation of chronic patterns of positive toxicologies for illicit substances, numerous unexplained absences, continued non compliance with the OTP rules and regulations and /or repeated relapses after significant time in treatment. However, the results of a single or isolated incident in this regard should not be considered as "not responding" to treatment. OTPs should intervene with a patient who is not responding to treatment including but not limited to discussion of the patient's treatment at a case conference, revision of the patient's treatment plan and documentation of any decisions in the patient record. If the treatment plan is revised, then going forward treatment plans are reviewed based on the date the plan was revised.

16. Q It states in 828.9 (i) Each OTP shall conduct multidisciplinary team meetings at least monthly. Patients who are non-responsive to treatment shall have their treatment plans revised. If the treatment plan is not modified then the OTP must notate the reason.
If the treatment plan is revised in compliance with 828.9 then going forward treatment plans are reviewed based on the date plan revised not admission date?

A. Yes.

17. Q. What documentation is required for counseling services?

A. A patient's record should contain documentation of all counseling services, immediate notations and summaries (828.10 (b) (6). The content and/or outcome of all visits must be fully documented in the individual patient's treatment record (828.23 (f). In addition, a summary of the content and outcome of all counseling services shall be entered in the patient's record at least monthly. Remarkable or notable occurrences shall be recorded in immediate notations. (828.9 (g)). The summary which is entered at least monthly is in addition to the documentation of counseling visits. OTPs must be in compliance with both requirements at this time. OASAS will review these requirements after the proposed regulation is submitted to the NYS Department of State and published in the New York State Register for public comment.

18. Q. Do the regulations require the physician's signature on the treatment plan?

A. No. As per 828.9 (d), (f) the treatment plan must be reviewed and signed and dated by at least three members of the multi-disciplinary team but not specifically the signature of the physician. Multi-disciplinary team is defined in Part 800.2 (a) (12). The physician's signature could be on the treatment plan but is only required at admission and annual review. If the physician does not sign the treatment plan, the physician is not relieved of the responsibility for the patient's treatment.

19. Q. It states in 828.10 (f) Each OTP must retain all patient records at least 6 years after discharge or contact, or three years after patient reaches the age of 18, whichever time period is longer. Why the 3 year option?
A. The three year option is for a patient who is discharged as a minor. The provision is to preserve legal rights of minors, in the event they had suffered some actionable legal harm. A patient's record must be kept for at least 6 years.

**Medication administration (828.11)**

20. Q. Section 828.11 Medication administration (h) A patient's approved medication shall not be withheld to enforce patient compliance with clinic rules or procedures, including but not limited to, rules on submitting to toxicology tests. Does this also pertain to take out medication or just daily dose? If a patient has a pickup schedule based on employment and fails to provide proof of employment by a certain, agreed upon date, can the program refuse to provide take out medication and be in compliance with this regulation.

A. This section is referring to patient's observed daily dose at the window, which can only be delayed, reduced or not administered for an emergent medical reason. This was added to the new regulations because in the past programs have abused withholding a patient's medication for many non-medical reasons.

An OTP may change a patient's take home schedule based on non-compliance with clinic policies for take-home (failure to provide proof of employment by an agreed upon date) and that OTP will be in compliance with this regulation. It is expected that an OTP will give a patient a warning prior to the change being made.

**Take-home medication (828.12)**

21. Q. In 828.12.b.2.v Take-home medication: it states employment or other productive activity. We have a large number of patients who are at or above retirement age or are on disability (SSI, SSD). They would not meet this criterion for take-home bottles. Do we have to complete an exemption request form for each individual who is otherwise stable but not engaged in a productive activity or not allow them take-home medication?

A. No. The regulation states "after a clinical review and consideration of the criteria below…" In considering the listed criteria, employment history, age, health and other conditions should be factored into the consideration. Therefore, a patient who is at or above retirement age would be allowed take-home medication as the patient is retired from employment, unable to work due to disability/illness, etc.

22. Q. Previously we needed OASAS approval for take-homes in excess of 14 bottles. Based on the new regulation 828.12 (e) with the one time, up to 30 take-home doses, this is no longer necessary, correct?

A. Yes, that is correct. OASAS approval would only be necessary for a one time take-home bottle release of 31 doses or more.

23. Q. Under the new regulations Part 828.12 3 (e), if a patient requests and receives 30 take-home bottles for a job training and 4 months later requires an additional 30 bottles, is that allowed under these regulations?

A. Yes. A prescribing professional can order up to 30 take-home doses for a patient at any one time. There is no limit on how many times a year an order for additional take- home medication may be made for an isolated circumstance. However, the order can not be made continuously to make a permanent schedule change.

24. Q. 828.12 (f) allows clinics to dispense methadone to someone other than the patient. Will a clinic be allowed to bill Medicaid for this type of activity? Is it allowable under our current billing structure and would it be allowable under APGs?

A. Prior to the new regulations, OTPs were allowed with OASAS prior approval to dispense to a "designated other". The new regulation allows for OTPs to dispense to a visiting nurse or nursing home personnel without prior approval and to family members or other persons with prior approval. Medicaid rules still apply and a patient, not the designated other, has to make a threshold visit in order for the OTP to bill Medicaid. Some of these situations are very short term; for example a patient has knee surgery and can not come in to the clinic for a period of time. Other times it is a long term arrangement where a patient may have a chronic debilitating illness. Under APGs the patient would need to come to the clinic face-to-face in order to bill for medication administration.

25. In 828.12 (f) what is required to release medication to a designated third party other than the patient?

A. During a patient's time in treatment at an OTP, there may be times when a patient is unable to go to the OTP to be medicated and receive take-home medication due to a medical condition, incarceration, residential treatment, transportation issue, etc. Prior OASAS approval is required to release a patient's medication to a designated third party (also known as a designated other) who is

not a visiting nurse or nursing home personnel, such as a non-minor family member, spouse, significant other, or home attendant. The request will only need to be made to OASAS once as long as the request does not specify a specific time frame for the arrangement. A new request to OASAS would need to be made if the designated third party changes. Patients who are physically compromised or unable to go to their OTP should identify and provide consent for a designated other to pick-up their medication. The designated other should meet with clinic staff who should explain clinic policies and procedures and ensure the designated other is responsible and can safely handle the medication. A request should then be made to OASAS (and CSAT) to approve the designated other. OTPs should use a "chain of custody" record whenever a designated other picks up medication for a patient. A "chain of custody" is a document containing the signatures of all people who have handled the medication. The completed "chain of custody" record should be placed in the patient's medical record.

Prior OASAS approval is not required for a release of medication to a designated third party that is a visiting nurse or nursing home personnel. This decision will be made on the reasonable clinical judgment of the prescribing professional as documented in the chart. As stated above, the patient's consent should be obtained and documented in the chart. The need to re-evaluate a non-OASAS approved designated other must be re-evaluated monthly and documented in the chart.

Prior OASAS (and CSAT) approval is not required if the patient is brought to the clinic by a third party, for example if a patient is incarcerated in jail and escorted by a police officer to the OTP or if a patient is residing in a nursing home or residential facility and escorted to the OTP by facility staff. A chain of custody form however, should be used in those situations.

26. Q. Can we keep a patient on a once-per-week visit schedule even if they are eligible for a less frequent one in order to remain financially viable?

A. No. In general, a patient's schedule should not be determined with income, coverage or payment as a criteria. A patient's schedule should be the most appropriate schedule for his/her overall progress in treatment, based on prudent clinical judgment and regulatory criteria. The number of visits required based on length of time in treatment is a minimum. A patient's schedule may exceed what is allowable by regulation as appropriately determined by the physician.

**Toxicology (828.13)**

27. Q. In the new regulations 828.13 (d) regarding frequency of toxicologies, "…at least bi-weekly thereafter". How is bi-weekly defined?

A. Bi-weekly is defined every two weeks.

28. 828.13 (d) (1) states an OTP shall conduct monthly tests only for those patients who complete at least three months of bi-weekly tests that show no positive illicit results and who are on a 30 day take-home schedule. Should the word "and" be "or"?

A. Both. The regulation should read "An OTP shall conduct monthly tests only for those patients who complete at least three months of bi-weekly tests that show no positive illicit results and/or who are on a 30 day take-home schedule."

29. Q. Can patients who are currently on a monthly toxicology testing schedule remain on a monthly testing schedule if they are not on a 30 day take-home schedule?

A. Yes as long as the patient's toxicology test results do not show more than one positive illicit result within three month period [828.13 (d) (2)].

30. Q. Our OTP computer system is designed to schedule patients "every 28 days" or "every 14 days" rather than "once a month" or "twice a month." Therefore we do not have any patients on a 30 day take home schedule. Does this mean that we cannot have any patients on a monthly toxicology testing schedule?

A. No. The intention of the regulation is that patient should be on a once per month schedule in order to be have toxicology testing monthly.

31. Q. I am also confused by the wording in 828.13(d) (2). Does it mean that a single positive toxicology requires resuming bi-weekly testing or one positive result does not but more than one positive result does?

A. Per 828.13 (b) no significant treatment decision shall be based solely on a single test result. Toxicology testing is considered a "significant treatment decision". Therefore one single positive illicit toxicology result does not require resuming bi-weekly testing.

**Staffing (828.14)**

32. Q. A nursing supervisory position is no longer a mandated position?

A. The nursing requirements in the new regulations are the same as in old regulations: 2 FT nurses for up to 300 patients at least one of whom is a registered nurse. The registered nurse shall be responsible for the general supervision of the nursing staff.

33. Q. 828.14 (i) states at least 50% of all counselors on staff must be QHP…for period commencing effective date of this Part and ending one year thereafter at lest 35% of aggregate clinical staff…from one year to two years 40% of clinical staff QHP and after two year period 50% of clinical staff QHP. Does this mean 50% of clinical staff does not just include counselors? Who is considered clinical staff?

A. The regulation should state clinical staff (not counselors) throughout section. Clinical staff member is defined in Part 800.2 (4). "Clinical staff member" means an individual employed by the governing authority that is regularly supervised, receives regularly scheduled in-service training, and provides clinical services as required by this Part.

34. Q. Is the % QHP across division if multiple PRUs or per PRU?

A. 50% of clinical staff must be QHP at each individual OTP PRU.

35. 828.14 (i) Staffing states at least fifty percent of all counselors on staff must be Qualified Health Professionals (QHPs) or CASAC trainees. Does a Licensed Mental Health Counselor (LMHC) count as a QHP?

A. Yes a LMHC may count as a QHP if an OTP receives OASAS approval through a waiver request. "LMHC" is not listed under Part 800.2 (a)(15), however, an OTP may request a waiver from the Waiver Committee to include LMHC and a LMHC who also meets the additional training

/experience requirements of Part 800.2(a)(15) will be automatically approved to be considered a non-CASAC QHP upon submission of the waiver.

36. 828.14 (j) Does the designated Healthcare Coordinator have to be direct staff of a program? Could an OTP designate someone employed by another program/agency such as ARCS with which there is a service agreement?

A. Per regulation each program needs to have an OTP staff person as the designated Healthcare Coordinator. The designee does not have to be a new hire. The designee can not be contracted with an outside person/agency.

37. Q. Re 828.14 (k): Each OTP can employ security guards to provide security for the OTP, its occupants and operations. Security guards are not clinical staff and shall not have any clinical responsibilities or be involved in clinical services or clinical activities..." Does this mean that only personnel who would otherwise qualify for a medical or counseling position will be allowed to hand out the labels and bottles for routine urine collection?

A. No. This regulation pertains only to the role of security guards.

38. Q. Regarding staffing, if none of our counselors at present are CASAC-Ts or QHP, are we expected to let go of current employees in order to comply with the new regulations?

A. OTPs must be in compliance with the regulations in the stated timeframes. However, instead of replacing excellent staff, staff could be encouraged to pursue a CASAC-T. While there are several ways to obtain a CASAC Trainee, those having a 4 year degree (Masters) in a Human Services field will be able to acquire the CASAC-T easily within the stated timeframe by meeting **one** of the following:

- 4,000 hours of work experience (Masters Degree substitutes for 4,000 hours or work experience)
  and
- 85 hours of education/training, obtained within 10 years from submission of the application, relating to the knowledge of alcoholism and substance abuse

*Or*

- 350 hours of education/training, obtained within 10 years from submission of the application, in the following areas, as follows:

  85 hours relating to the knowledge of alcoholism and substance abuse
  150 hours related to alcoholism and substance abuse counseling
  70 hours related to assessment; clinical evaluation; client record keeping and discharge planning
  45 hours related to professional and ethical responsibilities

Additionally, effective immediately, OASAS has elected to grant a waiver to persons whose CASAC, CPP, or CPS credential has expired for **two or more years** which will permit them to apply **now** to reinstate their credential using the fee structure that will be adopted when the new Part 853 Credentialing Regulations are promulgated. This new fee structure will significantly reduce the cost of reinstatement from the current maximum of $650 (for applicants more than 5 years expired) to a maximum of $350 ($150 renewal fee and $200 in late fees).

For further information on the CASAC Trainee, please call the OASAS Credentialing Unit at 800-482-9564 (option 2).

**Continuing care (828.19)**

39. Q. When does the clock start for how long a patient may remain in continuing care?

A. A patient may remain in continuing care for no more than 4 months from 2/8/10 which is the date the new emergency Part 828 regulations became effective.

40. Q. Can an OTP prescribe buprenorphine to a patient who has completed a methadone taper in continuing care?

A. No, continuing care treatment is a protocol for a patient who has completed an opioid maintenance taper whether the approved medication was methadone or buprenorphine, therefore the patient should not be receiving any approved medication at the OTP including a prescription for buprenorphine while in continuing care.

**Community relations (828.21)**

41. Q. 828.21 (b) the office shall require such policy to include forming a community committee which meets regularly to discuss actions to improve community relations. The old regulations stated may require. Shouldn't the committee be based on need?

A. The regulation requires a community relations policy to include forming a community committee.

**Standards pertaining to Medicaid reimbursement (828.23)**

42. Q. 828.23 (a) If a provider can only bill Medicaid for patients that make a threshold visit can fee paying patients be billed in same situation? There is concern about having 2 different standards.

A. Yes. Fee paying patients should be billed for weekly threshold visits only. There should not be a separate standard.

43. Q. 828.24 (c) if the Medicaid weekly fee is only for admitted patients, can providers bill patients separately for pre-admission services?

A. No. Part 828 OTPs receive a weekly threshold visit only and it is to be used AFTER the patient has been admitted to the Part 828. The weekly Medicaid rate is an all-inclusive rate. Services can not be charged separately.

In response to questions regarding **prescribing professional** as defined in 828.4 (r), please read the summary below.

**Prescribing Authority for Nurse Practitioners (NP) and Physician Assistants (PA) for Methadone**

Methadone for opioid addiction is regulated through licensed facilities including CSAT, DEA, Department of Health, OASAS and the State Education Department.

## CSAT

Admitting the patient to maintenance or detoxification treatment must be done by a physician. This cannot be deferred under any circumstance. The expectation is that the physician sees every patient face to face as part of the admission. In an emergency, a physician can be provided with the results of a physical examination by a qualified health care provider, by phone or fax and the physician admits the patient over the phone based upon that assessment and determines initial dose to be administered to patient. The patient record must be signed by the program physician within 72 hours. (see 42 CFR 8.12(e) and (f) (2)).

Practitioners, or agents of practitioners who are licensed under State law and registered under Federal law, may administer or dispense opioid agonist treatment medications. In New York, physician assistants under the supervision of a physician, and nurse practitioners working with a collaborative agreement, are authorized to modify patient medication levels and take-home schedules (see 42 CFR 8.12(h)(4)(1)).

Non-physician health care professionals are permitted to conduct various activities under the regulations. For example, under 42 CFR 8.12(f), an authorized health care professional under the supervision of the program physician may conduct the required initial physical examination. On the other hand, only a medical director or program physician shall determine a patient's eligibility for take-home medications under (see 42 CFR 8.12 (i) (2)).

Under the regulations, the medical director and program physicians are responsible for program-wide medication dosing and administration policies. In addition, significant deviations from approved product labeling must be documented by a program physician and medical director (see 42 CFR 8.12 (h) (4)).

## Drug Enforcement Agency

Each practitioner may administer or dispense directly ***(but not prescribe)*** methadone to a narcotic dependant person for the purpose of maintenance or detoxification treatment if the practitioner meets both of the following conditions (see 21 CFR §1306.07):

(1) "The practitioner is separately registered with DEA as a narcotic treatment program".

(2) "The practitioner is in compliance with DEA regulations regarding treatment qualifications, security, records, and unsupervised use of the drugs pursuant to the Act".

## New York State Public Health Law

Controlled substances may be prescribed for, or administered or dispensed to an addict or habitual user:

Methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be administered to an addict by a practitioner or by his designated agent acting under the direction and supervision of a practitioner, as part of a substance abuse or

chemical dependence program approved pursuant to article twenty-three or thirty-two of the mental hygiene law (see Title 5 §3351 (1)(5)).

**New York State OASAS**

"A Prescribing Professional is any medical professional appropriately licensed under New York State law and registered under federal law to prescribe approved medications". (MH Chapter 21 Part §828.4(r)).

**Physician's Assistants**

Section 3703(3) of the Public Health Law authorizes a registered physician's assistant to prescribe controlled substances – including Schedule II who is registered with the DEA beginning December 13, 2007. The law requires such prescribing to be:

- "In good faith and in the physician's assistant's lawful scope of practice";
- "Authorized by the physician's assistant's supervising physician";
- "For patients under the care of the supervising physician".

Methadone, a schedule II medication, can be prescribed by a PA when treating for pain management.

**Nurse Practitioners**

A licensed Nurse Practitioner who is registered with the DEA is authorized to prescribe controlled substances – including Schedule II as evidenced in a letter that was jointly signed by NPANYS and NYSNA dated Nov. 2005 to then NYS Department of Health Commissioner Novello which stated that NPs are authorized by NYS law to prescribe schedule II-IV medications. Methadone, a schedule II medication, can be prescribed by an NP when treating for pain management.

**Synthesizing the law, as it pertains to Methadone, the analysis is as follows:**

**If an NP or PA is licensed and has received a DEA number they may *write orders* in an OTP to modify patient medication levels, PA's are required to be under the supervision of a physician. NP's and PA's may not admit a patient to an OTP nor can they prescribe methadone for addiction.**

**Buprenorphine**

Buprenorphine is the only Schedule III medication for which law explicitly mandates that **only physicians can prescribe it** (Drug Addiction Treatment Act. (2000). Pub. L. No. 106-310, Div. B, Title XXXV, Section 3502(a)). (October 17, 2000) an authorized physician may prescribe, administer or dispense an approved controlled substance, and a licensed registered pharmacist may dispense an approved controlled substance, to a patient participating in an authorized controlled substance maintenance program approved pursuant to Article 32 of the Mental Hygiene Law for the treatment of narcotic addiction.

In addition an authorized physician prescribing an approved controlled substance for the treatment of narcotic addiction, in addition to preparing and signing an official New York State prescription in accordance with Section 3332 of the Public Health Law and Section 80.69 of this Part, shall also write his/her unique DEA identification number on the prescription.