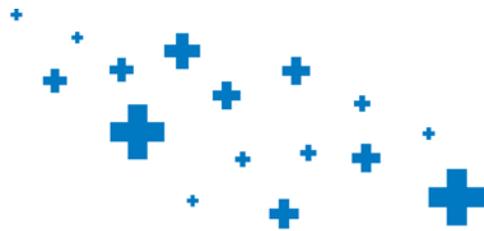




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## **Buprenorphine Medication Assisted Treatment (MAT) Program Description Division of TennCare**

**BCBST Tracking #: 18-068**

### **Overview of the Opioid Use Disorder Medication Assisted Treatment Program**

The Division of TennCare along with the contracted Managed Care Organizations (MCO), Amerigroup, BlueCare and United Healthcare, has determined the need for a comprehensive network of providers who offer specific treatment for members with opioid use disorder (OUD). These providers may be agencies or licensed independent practitioners, but all must attest to provide treatment as outlined in this program description to be included in this network.

Medication Assisted Treatment (MAT) for persons diagnosed with opioid-use disorder is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. The duration of treatment should be based on the needs of the persons served. The Food and Drug Administration (FDA) has approved several medications for the use in treatment of opioid-use disorder which include buprenorphine containing products and naltrexone products.

Treatment with buprenorphine for opioid use disorders is considered an evidence-based best practice by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center and the American Society of Addiction Medicine (ASAM) for substance abuse treatment. This Buprenorphine MAT Program Description outlines treatment and clinical care activities expected of providers who prescribe buprenorphine products and professionals who provide therapy, care coordination or other ancillary services for those members who are being treated with buprenorphine products. For providers who prescribe naltrexone based products, refer to Naltrexone MAT Program Description

### **Treatment Elements**

The required treatment elements for providers rendering Medication Assisted Treatment (MAT) using buprenorphine are as follows:

MAT Pharmacy Benefit:

- The preferred medication is the buprenorphine/naloxone combination (as covered by the TennCare formulary) for induction as well as stabilization unless contraindicated (e.g. pregnancy) and then the buprenorphine monotherapy is recommended. The buprenorphine/naloxone combination serves to minimize diversion and intravenous abuse.
- The buprenorphine/naloxone combination prescribed should be covered by the TennCare formulary and adhere to all prescribing protocols of the TennCare pharmacy benefits manager. TennCare's pharmacy benefits manager will also work with providers included in this network to reduce barriers

to access, support an efficient prior authorization process when required, and regularly update the formulary to support appropriate evidence-based buprenorphine/naloxone products for members.

**Provider Eligibility:**

- A physician who holds an unrestricted license from the Tennessee Board of Medical Examiners or the Tennessee Board of Osteopathic Examination and holds an active DATA 2000 waiver (DEA certified to prescribe buprenorphine) would conduct a full patient evaluation including substance use, psychiatric and a medical exam using standardized assessment and evaluation tools that have been peer reviewed and validated.

**MAT Clinical Elements and Supportive Elements:**

- A physician would document initial screenings of each patient to determine whether the patient meets the diagnostic criteria for an opioid use disorder as defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or ICD-10.
- Regular physician office visits should be scheduled:
  - Weekly for patients in the induction and stabilization phase,
  - Every two to four weeks for patients in the maintenance phase and
  - At least every two months for patients who have been in maintenance phase for one year or longer.
- Discontinuation of medication would occur if and when the member has achieved maximum benefit from treatment. Abstinence from opioids is desirable, but evidence shows that many people require ongoing treatment.
- Buprenorphine would be tapered slowly while appropriate psychosocial services continue to be provided. Beneficiaries should be assessed for continued stability. Involuntary termination of treatment may occur under certain circumstances but abandonment should be avoided and physicians should have written policies and procedures that should be discussed with beneficiaries who should agree to comply with these policies.
- Program would provide initial and on-going training and resources to patients receiving care including:
  - Treatment options, including detoxification supported by MAT, and the benefits and risks associated with each treatment option;
  - The risk of neonatal abstinence syndrome and use of voluntary long-acting reversible contraception for all female patients of child bearing age and potential (ages 15-44);
  - Prevention and treatment of chronic viral illnesses, such as HIV and hepatitis C;
  - Expected therapeutic benefits and adverse effects of treatment medication;
  - Risks for overdose, including drug interactions with CNS depressants, such as alcohol and benzodiazepines, and relapsing after periods of abstinence from opioids; and
  - Overdose prevention and reversal agents.

## Treatment Protocols and Guidelines

### **Overview of MAT Treatment Phases**

The **Induction Phase** is the medically monitored startup of buprenorphine treatment performed in a qualified physician's office or certified OTP using approved buprenorphine products. The medication is administered when a person with an opioid dependency has abstained from using opioids for 12 to 24 hours and is in the early stages of opioid withdrawal. It is important to note that buprenorphine can bring on acute withdrawal for patients who are not in the early stages of withdrawal and who have other opioids in their bloodstream.

The **Stabilization Phase** begins after a patient has discontinued or greatly reduced their misuse of the problem drug, no longer has cravings, and experiences few, if any, side effects. The buprenorphine dose may need to be adjusted during this phase. Because of the long-acting agent of buprenorphine, once patients have been stabilized, they can sometimes switch to alternate-day dosing instead of dosing every day.

The **Maintenance Phase** occurs when a patient is doing well on a steady dose of buprenorphine. The length of time of the maintenance phase is tailored to each patient and could be indefinite. Once an individual is stabilized, an alternative approach would be to go into a medically supervised withdrawal, which makes the transition from a physically dependent state smoother. People then can engage in further rehabilitation—with or without MAT—to prevent a possible relapse.

### **Induction and Stabilization Phase:**

- (a) A patient in the induction or stabilization phases of treatment shall:
- Have weekly office visits scheduled;
  - Receive appropriate counseling sessions at least twice a month, as defined in **Program Components**, below
  - Be subject to one (1) observed drug screen at least weekly; and
  - Receive care coordination services weekly, if indicated.

### **Maintenance Phase:**

- (b) A patient in the maintenance phase of treatment for less than one (1) year shall:
- Have a scheduled office visit at least every two (2) to four (4) weeks;
  - Receive counseling sessions at least monthly, as defined in **Program Components** below;
  - Be subject to a random observed drug screen at least eight (8) times annually; and
  - Receive care coordination services at least monthly, if indicated.
- (c) A patient in the maintenance phase of treatment for one (1) year or more shall:
- Have a scheduled office visit at least every two (2) months;
  - Recommend counseling sessions at least monthly unless clinically stable and with continued signs of recovery, as defined in **Program Components** below;
  - Be subject to a random observed drug screen at least four (4) times annually; and
  - Receive care coordination services at least monthly, if indicated.
  - Coordinate care with patient's primary care physician

### **Detailed Drug Screen Protocol**

Appropriate drug screening and the use of consistent drug screening protocols are an important and required process in the delivery of MAT services. Providers must ensure that the following or similar protocol is in place:

- (a) Random observed urine drug screening and other adequately tested toxicological procedures shall be used for the purposes of assessing the patient's abuse of drugs and evaluating a patient's progress in treatment.
- (b) Drug screening procedures shall be individualized and shall follow the required drug screen frequency described in phases of treatment.
- (c) More frequent collection and analysis of drug screen samples during episodes of relapse or medically-supervised or other types of withdrawal may occur.
- (d) Collection and testing shall be done in a manner that assures that samples collected from patients are unadulterated. Any ordered qualitative/ confirmatory screens should be ordered for the drugs or drug classes in question. Collection and testing shall include random direct observation that is conducted professionally, ethically, and in a manner which respects patient privacy.
- (e) A positive test is a test that results in the presence of any drug or substance that is illegal, for which the patient cannot provide a valid prescription, or prohibited by the Facility. Any refusal to participate in a random drug test assigned by the Facility shall also be considered a positive result.
- (f) Discuss any unexpected results, including both unexpected positive results and negative results, with the member immediately. Appropriate changes to treatment plan and interventions should follow any unexpected results.
- (g) The Facility shall document both the results of toxicological tests and the follow-up therapeutic action taken in the patient record.
- (h) Absence of medications prescribed by the Facility for the service recipient shall be considered evidence of possible medication diversion and evaluated by the program physician, accordingly.
- (i) Nothing shall preclude any Facility from administering any additional drug tests it determines necessary.

### **Program Components**

In addition to providing high quality evidence-based treatment, providers must also **ensure the availability** of the program components listed below. Providers must also make available relevant documentation for the quality-of-care reviews performed by the Managed Care Organizations:

- Include protocols to query the Controlled Substance Monitoring Database (CSMD) each time a prescription is written or electronically prescribed and dispensed
- Employ, contract, or partner with a behavioral health counselor to provide psychosocial assessment<sup>1</sup>, addiction counseling, individual/group counseling, self-help and recovery support, and therapy for co-occurring disorders (The member's counselor may be either co-located with the MAT provider or may participate in an SUD practice attended by the member)
- Include confidential documentation of care including individualized treatment plans completed within 30-days of admission and reviewed every six months thereafter
- Include and document appropriate behavioral health counseling sessions per each phase of treatment<sup>2</sup>:

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<sup>1</sup> A standardized, evidenced-based psychosocial assessment is recommended (e.g. DLA-20 or QOL-10)

<sup>2</sup> Behavioral Health Counseling is defined as individual or group sessions of no less than 30 minutes in duration.

Provider's counseling professional should hold at least a master's degree in the mental health discipline and be under the direct supervision of a licensed mental health provider practicing within their scope of licensure.

- At least twice a month for patients in the induction and stabilization phase
- At least monthly for patients in the first year of maintenance phase (for patients who remain in the maintenance phase beyond one year, behavioral health counseling at least monthly may still be recommended;)
- Employ, contract, or partner with a local care coordination resource to
  - Facilitate communication between prescriber and counselor
  - Maintain telephone contact with member, as needed
  - Coordinate urinary drug screens (UDS)
  - Conduct pill or film counts and refer members for appropriate counseling
  - As indicated, provide other recovery support services (e.g. 12-step)
- Employ, contract, partner, or show effort towards, engagement with a Certified Peer Recovery Specialist (has certification through TDMHSAS) in the community for consumer education, treatment engagement, and recovery planning;
- Include appropriate care coordination:
  - At least weekly for patients in the induction and stabilization phase
  - At least monthly for patients in the maintenance phase
- Perform routine and random UDS checks as follows:
  - One observed drug screen weekly for patients in the induction and stabilization phase
  - At least eight times per year for patients in the maintenance phase for less than a year
  - At least four times per year for patients in the maintenance phase for more than a year
- Maintain a Diversion Control Plan and perform routine and random pill/film counts
- Maintain a plan to address medical emergencies including naloxone on-site
- Maintain a plan to address psychiatric emergencies including involuntary hospitalization
- Communicate timely with other providers who are treating the member and with member's informal support system.

While counseling is a recommended component of Medication Assisted Treatment, a member may continue to receive prescribed buprenorphine even if not participating in the counseling. This decision should be based on the provider's clinical judgment and the member's overall involvement in their treatment and recovery.

In instances when the provider is unable to link to a counseling professional, the contracting MCO can provide assistance to identifying and connecting to counseling services. A MAT network provider can reach out to the MCO for support at the following numbers:

- Amerigroup: Provider Services at (800) 454-3730
- BlueCare: MAT Referral Line at (800) 814-8936
- United Healthcare: Provider customer service at (800) 690-1606

### **Monitoring Quality of Care**

An annual quality of care review shall be collaboratively conducted by the provider and MCO. MAT providers shall co-operate with on-site monitoring performed by the Managed Care Organizations. The MAT provider quality of care review shall include:

- Inspection of medical records for adherence to MAT program standards/requirements, protocols, and clinical treatment guidelines
  - Functional assessment reviews
- Assessments of member experience, completed and collected at providers' offices. At a minimum, member perspectives shall be measured regarding:
  - Support received during MAT treatment initiation
  - Outpatient MAT provider identification
  - 7-day follow-up behavioral and/or physical health appointment accessibility
  - Ease of pharmacy service
  - Ability to obtain prescription fills for both MAT and psychiatric medications

Monitoring of non-MAT SUD providers shall focus on adherence to clinical treatment guidelines as documented in medical records.

#### **Quality Review:**

The Managed Care Organizations will provide to each MAT provider in its quality of care monitoring process, a focused assessment of the treatment patterns and patient health outcomes for Opioid Use Disorders and Substance Abuse Disorders. The MCO, in collaboration with the MAT provider, will provide analysis using nationally available measures, claims based metrics, and through medical record assessment of treatment practices and patterns at the provider level. The quality review will focus on, but is not limited to, outcome measures in the following clinical and treatment areas:

- (a) Length of MAT treatment
- (b) Use of behavioral health services during MAT
- (c) Urine Drug Screen frequency
- (d) Health care utilization patterns of MAT patients (e.g. emergency room visits, hospitalizations)
- (e) Concurrent use of benzodiazepines and/or opioids while on MAT

#### **References and Resources**

Additional resources, references, and published comprehensive best practice guidelines for the use of buprenorphine in treating opioid use disorders are listed below. This program description and the treatment elements have been developed from these documents for buprenorphine treatment.

#### **SAMHSA Resources:**

- For SAMHSA resources, please visit: <https://www.samhsa.gov/> and <http://store.samhsa.gov>
- SAMHSA Treatment Improvement Protocol (TIP) # 40, "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction"

- SAMHSA Treatment Improvement Protocol (TIP) # 43, “Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs”
- SAMHSA Treatment Improvement Protocol (TIP) # 63, “Medications for Opioid Use Disorder”  
ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use
- Examples of screenings are found at <http://www.samhsa.gov/sbirt>

Tennessee Nonresidential Buprenorphine Treatment Guidelines:

- For the complete copy of the guidelines, please visit:  
[https://www.tn.gov/content/dam/tn/mentalhealth/documents/2018\\_Buprenorphine\\_Treatment\\_Guidelines.PDF](https://www.tn.gov/content/dam/tn/mentalhealth/documents/2018_Buprenorphine_Treatment_Guidelines.PDF)

Tennessee Board of Osteopathic Examiners

<https://www.tn.gov/health/health-program-areas/health-professional-boards/oste-board.html>

Tennessee Board of Medical Examiners

<https://www.tn.gov/health/health-program-areas/health-professional-boards/me-board.html>