A New Twist to an Old Issue: Office-Based Opioid Addiction Treatment

During my many years conducting administrative hearings for the old Department of Licensing and Regulation, the issue of treating opioid addicted patients in the office setting would occasionally rear its ugly head. I say “ugly head” because in most instances this treatment method came to the attention of state regulators as a result of a complaint being filed against a physician who had been prescribing narcotics for treatment of pain. The usual scenario was that a patient with a valid need for treatment of pain had been prescribed narcotics and eventually became addicted. The physician, in an attempt to wean the patient off the prescription, would continue to prescribe after the termination or resolution of the underlying reason for the initial pain treatment. The physician then found him or herself being charged with inappropriately prescribing narcotics. This type of situation frequently led to disciplinary action being taken due to the physician’s inappropriate treatment modality. I have to say that in some of those cases the physician got in over his or her head and was trying to do the “right thing” but ended up with the wrong result.

Fast forward to the year 2002. On October 8, 2002, the United States Food and Drug Administration announced approval of office-based treatment of opioid-addicted patients by allowing qualified physicians to prescribe FDA approved Schedule III, IV, and V medications.

This announcement came as a result of the “Drug Addiction Treatment Act of 2000” (DATA). This legislation is of particular interest to state medical boards because it provides for significant changes in the oversight of the medical treatment of opioid addiction.

DATA states that physicians seeking approval must demonstrate required qualifications as defined in the law, be licensed in the state where the physician practices, and hold an addiction related certification from the American Board of Medical Specialties, the American Osteopathic Association, or the American Society of Addiction Medicine. As an alternative to the certification requirement, physicians may qualify if they receive at least eight (8) hours of training provided by designated medical and specialty organizations in the care of opioid-addicted patients. The DATA also requires that physicians be able to refer patients for counseling and appropriate ancillary services. Under the law, each physician or practice is allowed to treat a maximum of 30 such patients simultaneously.

DATA provides that additional qualifications may be required by individual states.
Finally, physicians must obtain a waiver from the Substance Abuse and Medical Health Services Administration (SAMHSA) in order to provide office-based treatment modalities for opioid addicted patients.

The Federation of State Medical Boards has developed *Model Guidelines for Opioid Addiction Treatment in the Medical Office*.

So what does all this mean? Not a whole lot to some physicians but a great deal to those who wish to develop office-based treatment programs. The state Department of Consumer and Industry Services and the medical boards will very likely be considering adoption of some form of the *Model Guidelines*. This new program presents many opportunities for assisting addicted individuals in a less institutional setting and hopefully removing some of the stigma associated with the current programs.

However, as always, the balancing act between appropriate and inappropriate prescribing and legitimate medical use must be thoroughly examined. The preamble to the *Model Guidelines* states: “The Board will consider appropriate prescribing, ordering, administering, or dispensing of these medications for opioid addiction to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of opioid addiction and in compliance with applicable state and federal law.” The *Guidelines* go on to say that “the board will determine the appropriateness of prescribing based on the physician’s overall treatment of the patient and on available documentation of treatment plans and outcomes.”

Herein lies the possible rub. Setting aside all other factors, if a complaint is filed and an expert looks at the case to determine appropriate prescribing for a legitimate medical purpose, the expert is expected to look at accepted scientific knowledge of the treatment of opioid addiction. Let me suggest that experts may differ in this most critical area and that your treatment modality might be found lacking. You are then faced with possible disciplinary action against your license. Sound far fetched – not from my years of hearing cases.

My advice to those who might want to establish such a program is to keep a close eye on the progress of rules or guidelines in Michigan. Your professional associations will be a major player in the adoption of the ultimate regulations in Michigan. Let them know how you feel. ©2003 by Basso & Basso Consulting Services LLC.

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