Frequently Asked Questions about Medication Assisted Treatment within Community Clinics and Health Centers
updated: 11/20/19

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1. ***What is Medication-Assisted Treatment (MAT)?***
   Medication Assisted Treatment is an evidence based intervention that combines behavioral therapy and medications to treat substance use disorders, like alcohol and opioid dependency. MAT for opioid addiction is subject to federal legislation, regulations, and guidelines, including panel size limitations and prescriber training requirements issued under DATA 2000. There are three approved pharmaceutical interventions: buprenorphine, long-acting injectable naltrexone (Vivitrol), and methadone. Methadone is exclusively available through licensed narcotic/opioid treatment programs. Most FQHCs providing MAT services will provide buprenorphine or Vivitrol.

2. ***How does a practitioner apply to prescribe or dispense buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000)?***
   Practitioners may apply to the Substance Abuse and Mental Health Services Administration (SAMHSA) for approval to prescribe buprenorphine medications for the purposes of treating opioid use disorder. Practitioners are required to complete additional training to qualify for a waiver to prescribe and dispense buprenorphine. More information on training resources and the process to apply may be found on the SAMHSA website.

3. ***What types of providers are eligible to apply for an X-waiver to prescribe buprenorphine medications?***
   The following practitioners are eligible to apply for a DATA 2000 X-Waiver to prescribe buprenorphine:
   - Physicians
   - Physician Assistant (PA)
   - Nurses, including: Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM)

   Each provider must possess their own X-Waiver. Additional training and supervisory requirements apply to advanced practice clinicians (APCs) prescribing buprenorphine and other medications to treat opioid use disorder.

4. ***Is a supervising physician of an X-waivered APC also required to have an X-waiver?***
   No. At least one supervising physician (APCs may have multiple supervising physicians) must meet the definition of a "qualifying physician" under the Comprehensive Addiction and Recovery Act of 2016.[1] A qualifying physician is someone who is eligible for an X-waiver, but may not necessarily have an X-waiver themselves.

5. ***Must the supervising physician have experience prescribing medications for opioid use disorder treatment?***
   Technically, no - but as a best practice it is **strongly** recommended that a supervising physician have experience. From a purely technical and legal point of view, an X-waivered physician who does not have experience in prescribing medications for opioid use disorder treatment may supervise an X-

[1] Title 21 United States Code (USC) Controlled Substances Act, as amended by the Comprehensive Addiction and Recovery Act of 2016, 21 U.S.C. § 823(g)(2)(G)(ii). Also, see: https://www.asam.org/docs/default-source/education-docs/cara-language-on-qualifying-physicians.pdf?sfvrsn=26427ec2_2

waivered APC. However, as a generally accepted rule in the healthcare industry (by both providers and regulators) a physician should not allow a supervised APC to perform services that the physician cannot do themselves.

6. ***Does the supervising physician need to be physically present in the clinic when the patients managed on buprenorphine are seen by an APC?***
   No. With respect to physician assistants, a supervising physician is not required to be on-site but must be available in person for by electronic communication at all times when the physician assistant is caring for patients.[2]
   For advanced practice nurses, physician supervision does not require the physical presence of the physician, but does require the physician to be available by telephonic contact at the time the patient is being examined.[3]

7. ***Do patients managed on buprenorphine by an APC count toward the physician's patient limit?***
   This is somewhat unclear. Under federal law, a patient in this context is "any individual who is dispensed or prescribed covered medications by a practitioner."[4] In other words, the definition links the patient to the practitioner who provides the patient with his or her covered medications through dispensing or by prescription. "Patient limit" is defined as the maximum number of individual patients that a practitioner may dispense or prescribe covered medications to at any one time.[5] Thus, unless the supervising physician is prescribing or dispensing the medications, the patient would not count toward the physician's limit.

   However, under California law, neither physician assistants nor advanced practice nurses are given explicit prescriptive authority; they may *furnish*[6] drugs under supervision,[7] but some may argue that under a strict interpretation of the relevant scope of practice laws, they cannot write prescriptions for medication. In other words, under this strict interpretation of state law, a patient who receives prescription medication by an X-waivered APC is necessarily receiving medication that was

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[2] Medical Board of California, FAQ – Supervising Physician Assistants: https://www.mbc.ca.gov/Licensees/Physicians_and_Surgeons/Physician_Assistants_FAQ.aspx. Note: the guidance on the Medical Board's website does not yet reflect changes to state law recently made by enacted legislation (SB 697) that substantially alter physician assistant scope of practice and supervisory requirements. These changes, which take effect January 1, 2020, generally allow for greater flexibility and independence for both physician assistants and supervising physicians, and do not impact the guidance provided in this FAQ. For more information, see https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB697

[3] Department of Consumer Affairs, Board of Registered Nursing, General Information: Nurse Practitioner Practice: https://www.rn.ca.gov/pdfs/regulations/npr-b-23.pdf

[4] 42 C.F.R § 8.2. See also: Medication Assisted Treatment for Opioid Use Disorders (Final Rule), available here: https://www.deadiversion.usdoj.gov/pubs/docs/SAMHSA_Regulations_275.pdf

[5] Id.

[6] Under California Business and Professions Code § 4026, "furnish" means to "supply [drugs] by any means, by sale or otherwise." This is technically different than a writing a prescription, though under § 4040 of the California Business and Professions Code, a prescription is defined to mean an oral, written, or electronic transmission order that is both (1) given individually for the person for whom ordered; and (2) issued by a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor under Section 3640.7 of the California Business and Professions Code . . . **or "if a drug order is issued under Section 2746.51, 2836.1, 3502.1 or 3460.5 by a CNM, NP, PA, or naturopathic doctor . . . ."** See, too, https://www.rn.ca.gov/pdfs/regulations/npr-i-16.pdf, which details the Board of Registered Nursing's requirement for advanced practice nurses to have a furnishing number and includes a discussion about the arguable differences between an "order," "furnishing," and "prescriptive authority."

[7] See, e.g., §§ 2746.51 (CNMs), 2836.1 (NPs), and 3502.1 (PAs) of the California Business and Professions Code.

prescribed by the supervising physician, not the APC – and thus, perhaps those patients should count toward the physician's limit.

While CPCA believes a stronger argument can be made that patients treated by an APC were not intended to not count towards a supervising physician's limit under federal law, we encourage providers to review this question internally and/or seek the advice of legal counsel to determine whether to include patients seen by APCs toward a physician's limit.

8. ***Where can I find clinical guidelines for providers working in opioid treatment?***
   There are several referral sources for up-to-date clinical guidelines and best practices for providers. While CPCA does not endorse any of these sources, we recommend providers consult:
   - California Society for Addiction Medicine: *Guidelines for Physicians Working in California Opioid Treatment Programs.*
   - California Substance Use Line: The California Substance Use Line is a free, 24/7 tele-consultation service for California clinicians. Staffed by experienced physicians and pharmacists who can answer confidential questions about substance use evaluation and management, including medications to treat opioid use disorder, the California Substance Use Line provides fast, reliable, patient-tailored guidance and resources that can facilitate substance use prevention and treatment efforts. Call any time, 24/7 at: (844) 326-2626.

9. ***Do I have to complete a change of scope to offer MAT?***
   HRSA: When a health center offers MAT as a part of their medical home services, that health center's HRSA Scope of Project should include Substance Abuse Services in form 5A.

   DHCS: The addition of MAT may be considered a triggering event for health centers to complete a scope of service change request for their PPS rate. Health centers should refer to the FQHC/RHC Change in Scope of Services Request Form at http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx

   Alternatively, FQHCs may elect to provide MAT services outside of their PPS rate and through the Drug Medi-Cal program. In this case, the FQHC would not be eligible to receive their PPS rate for MAT services, but may find flexibility in the provider types and spectrum of services available as a Drug Medi-Cal provider. FQHCs wishing to provide MAT outside of the PPS rate may have to undergo a DHCS Scope of Services PPS rate setting. Health centers should be aware of the possibility of enhanced auditing scrutiny if they seek to bill outside of their PPS rate. Careful review of the costs building a health center's PPS rate should be undertaken if an FQHC seeks to care out the MAT service. Contact CPCA for more information about this option.

10. ***Who is responsible for payment to the medical provider rendering MAT professional services within an FQHC?***
    Professional services surrounding MAT vary depending on the health center's care model. At a minimum, the health center can expect a clinical visit in primary care for medication induction. If the prescriber is in-network with a Managed Medi-Cal Plan and is prescribing as part of his or her normal, primary care scope of practice then the managed care plan is responsible for the professional fees.

    There may also be professional services rendered by an addiction counselor, therapist, or care/case manager, which are likely not eligible for separate reimbursement under the PPS rate. All PPS

billable provider/visit rules apply to MAT provided in a FQHC unless the MAT is specifically "carved out" and offered under a separate reimbursement system like Drug Medi-Cal.

Medications for SUD are 'carved out' of managed care and are billable to DHCS, so the dispensing pharmacy will process payment directly to the state.

In many cases, MAT services that are not provided at an FQHC are paid through Drug Medi-Cal contracts and either billed to the state, or county, in the case of DMC-ODS.

11. ***Am I subject to any additional privacy regulations because my health center offers MAT?***
In addition to HIPAA, health centers need to be mindful of how their current structure may or may not make them subject to title 42 of the Code of Federal Regulations Part 2 (42 CFR Part 2), the federal substance use disorder confidentiality regulations.

MAT services, like buprenorphine prescribing, may be effectively integrated into a health center's primary care services without subjecting the health enter to 42 CFR Part 2 regulations. Health centers are typically considered general medical facilities that are not subject to Part 2. However, if a behavioral health provider or primary care provider practicing at a health center (1) are part of a defined unit of the health center that 'holds itself out to the public' as providing SUD services, or (2) have as their main job function the provision of SUD services, then the provider may be subject to Part 2.

CPCA and HITEQ produced a webinar and Q&A presentation on the 42 CFR Part 2 Final Rule and Health Center Compliance. This webinar describes the changes made to 42 CFR Part 2 in 2017 and analysis from a legal and operational view how the changes may affect integrated MAT and SBIRT programs.

12. ***Can our health center offer MAT exclusively to patients who are not patients assigned to us through managed Medi-Cal?***
Medi-Cal patients have a federally guaranteed right to access FQHC services. Inasmuch as the FQHC provides MAT as a part of its HRSA scope of services, Medi-Cal patients may access MAT services at the FQHC. FQHCs are entitled to reimbursement at their PPS rate for face-to-face visits with FQHC billable providers.

It is possible that a Medi-Cal managed care plan may deny claims related to MAT services provided to patients who are not assigned to the FQHC. In this case, the FQHC should bill Medi-Cal using one the following HIPPA-compliant code sets:

- Licensed Clinical Social Worker (previously code 11): Revenue Code 0900, Procedure Code T1015, Modifier AJ, with the appropriate informational line(s)
- Psychologist (previously code 12): Revenue Code 0900, Procedure Code T1015, Modifier AH, with the appropriate informational line(s)
- Primary Care Psychiatrist (previously code 13): Revenue Code 0900, Procedure Code T1015, Modifier AG, with the appropriate informational line(s)

If the service is covered by the managed care plan, and the patient is assigned to the FQHC by that managed care plan, the FQHC bills the managed care plan and submits a managed care differential rate (previously code 18) claim to Medi-Cal. FQHCs should use the HIPPA-compliant billing code set "Revenue Code 0521, Procedure Code T1015, Modifier SE, with the appropriate informational lines"

to Medi-Cal for reimbursement of the differential rate. The health center must keep denials on file and will be made whole at reconciliation.

If the service is covered by the managed care plan, but the patient is not assigned to the FQHC, the FQHC should still bill the managed care plan and will likely receive a denial that should be kept on file. The FQHC should submit a differential rate claim to Medi-Cal and will be made whole.

California Primary Care Association

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