

**RULES  
OF  
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES  
DIVISION OF ADMINISTRATIVE AND REGULATORY SERVICES**

**CHAPTER 0940-05-35  
MINIMUM PROGRAM REQUIREMENTS FOR NONRESIDENTIAL OFFICE-BASED OPIATE  
TREATMENT FACILITIES**

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**0940-05-35-.01 PURPOSE.**

The rules in this chapter implement the law relative to licensure and regulation of nonresidential office-based opiate treatment facilities pursuant to Chapter 912 of the Public Acts of 2016.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

**0940-05-35-.02 DEFINITIONS.**

- (1) Definitions of general terms used in these rules can be found in Rules Chapter 0940-05-01.
- (2) Definitions specific to this chapter are as follows:
  - (a) “Nonresidential office-based opiate treatment facility” or “Facility” or “OBOT” is a service entity that includes, but is not limited to, stand-alone clinics, treatment resources, individual physical locations occupied as the professional practice of a prescriber or prescribers licensed pursuant to Title 63, or other entities prescribing products containing buprenorphine, or products containing any other controlled substance designed to treat opioid use disorder by preventing symptoms of withdrawal to fifty percent (50%) or more of its patients and to one hundred fifty (150) or more patients.
  - (b) “Buprenorphine” means a semi-synthetic opioid partial agonist that activates the opioid receptors but not to the same degree as full agonists such as morphine and heroin.
  - (c) “Case Management/Care Coordination” means a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.
  - (d) “Controlled Substance Monitoring Database” or “CSMD” means a program administered by the Tennessee Department of Health to monitor the prescribing and dispensing of Schedule II, III, IV and V controlled substances as set forth by T.C.A. Title 53, Chapter 10, Part 3.

(Rule 0940-05-35-.02, continued)

- (e) “Counseling” or “Counseling Session” means a face-to-face individual therapeutic counseling session lasting not less than twenty (20) minutes with a qualified provider, or a group educational session of no more than twenty (20) patients and lasting not less than fifty (50) minutes facilitated by a qualified provider. Counseling shall be focused on issues related to the patient’s opioid use disorder and shall not include discussions related to administrative procedures. Telehealth, pursuant to the Tennessee Code Annotated, may be utilized to facilitate counseling. Attendance of a 12-step program, such as Narcotics Anonymous, shall not be considered counseling. The Facility shall document each counseling session in the patient’s medical chart.
- (f) “DATA 2000 Waiver” means the registered authority given to a qualified health care professional by the U.S. Drug Enforcement Administration to prescribe FDA-approved narcotic medication for opioid detoxification or maintenance treatment pursuant to 21 U.S.C. § 823(g).
- (g) “DEA” means the United States Drug Enforcement Administration.
- (h) “Detoxification” or “Detoxification Treatment” means the dispensing of an opioid agonist treatment medication in decreasing doses to the patient to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or substantial use of an opioid drug and as a method of bringing the patient to a drug-free state within that period.
- (i) “Diversion Control Plan” means specific measures, including assigning responsibilities to medical and administrative staff, to reduce the possibility of diversion of controlled substances from legitimate treatment to illicit use.
- (j) “Facility Director” means the person designated by the Facility’s governing body who is responsible for the operation of the Facility, for the overall compliance with federal, state, and local laws and regulations regarding the operation of a non-residential office-based opiate treatment facility, and for all Facility employees. Non-physician facility directors shall not supervise medical staff.
- (k) “FDA” means the United States Food and Drug Administration.
- (l) “Governing Body” means the person or persons with primary legal authority and responsibility for the overall operation of the OBOT and to whom a director/chief executive officer is responsible. Depending upon the organizational structure, this body may be an owner or owners; a board of directors or other governing members of the licensee; or state, city, or county officials appointed by the licensee.
- (m) “Inspection” means any examination by the Department or its representatives of an OBOT including, but not limited to, the premises, staff, persons in care, and documents pertinent to initial and continued licensing, so that the Department may determine whether an OBOT is operating in compliance with licensing requirements or has violated any licensing requirements. The term inspection includes any survey, monitoring visit, complaint investigation, or other inquiry conducted for the purposes of making a compliance determination with respect to licensing requirements.
- (n) “Medical Director” means a physician who meets the qualifications set out in 0940-05-35-.19(3)(b) and who has been designated by the governing body of the Facility to be responsible for the supervision of all medical staff at the Facility and the administration of all medical services offered by the Facility, including compliance with all federal, state and local laws and rules regarding medical treatment of opioid use disorder.

(Rule 0940-05-35-.02, continued)

- (o) "Medical Record" or "Medical Chart" means medical histories, records, reports, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries, x-rays, radiology interpretations and other written electronics, or graphic data prepared, kept, made or maintained in a facility that pertains to services rendered to patients.
- (p) "Medication Assisted Treatment" means use of a medication approved by FDA, in combination with counseling and behavioral therapies, for the treatment of an opioid use disorder.
- (q) "Multidisciplinary Treatment Team" or "Treatment Team" means professionals, which may include a licensed physician, licensed physician assistant, licensed nurse, qualified alcohol and drug treatment personnel, and/or mental health professionals, who assess, evaluate, or treat a patient.
- (r) "Office of Licensure" means the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) Office of Licensure.
- (s) "Opiate/Opioid" means a drug that contains opium, derivatives of opium, or any of several semi-synthetic or synthetic drugs with agonist activity at the opioid receptor.
- (t) "Observed Drug Screen" or "Observed Urine Drug Screening" means a test used to determine the presence of illicit drugs in an individual's body conducted by and in the presence of a Facility medical or lab staff or contracted medical or lab staff so as to ensure against the tampering with or falsification of the results.
- (u) "Patient" or "Service Recipient" shall refer to an individual receiving treatment for opioid use disorder at an OBOT.
- (v) "Physical Location" means real property on which is located a physical structure, whether or not that structure is attached to real property, containing one (1) or more units and includes an individual apartment, office, condominium, cooperative unit, mobile or manufactured home, or trailer, if used as a site for prescribing or dispensing products containing buprenorphine, or products containing any other controlled substance designed to treat opioid use disorder by preventing symptoms of withdrawal.
- (w) "Phases of Treatment" means the induction, stabilization, and maintenance phases associated with office-based opioid treatment as described in the Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: A Treatment Intervention Protocol published by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT).
- (x) "Program Physician" means any physician, including the medical director, who provides medical services to patients at the Facility.
- (y) "Qualified Provider" means a qualified mental health professional as defined in T.C.A. § 33-1-101(20), qualified alcohol and drug abuse treatment personnel as defined in 0940-05-01-.16(7), or treatment staff operating under the direct supervision of either a qualified mental health professional or qualified alcohol and drug abuse treatment personnel.
- (z) "Relapse" means a process in which an individual who has established abstinence or sobriety experiences a recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors.

(Rule 0940-05-35-.02, continued)

- (aa) "TDMHSAS" or "Department" means the Tennessee Department of Mental Health and Substance Abuse Services.
- (bb) "Treatment" or "Substance Abuse Treatment" means a broad range of services intended to assess status, reduce symptoms, or mitigate the effects of substance misuse, substance use disorders, or co-occurring disorders; reduce risk of relapse and associated harm; or restore or establish well-being for individuals and families; provided, that said practice may include, but not be limited to, care coordination, case management, medical, pharmacological, psychological, psycho-educational, rehabilitative or social services and therapies. The overall goals are to eliminate the substance abuse as a contributing factor to physical, psychological, and social dysfunction and to arrest or reverse the progress of any associated problems.
- (cc) "Treatment program" or "Substance Abuse Treatment Program" means an organized system of services containing a mission, philosophy, and model of substance use disorder treatment designed to address the needs of clients.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.03 APPLICATION OF THE RULES.**

- (1) The licensee of an OBOT shall comply with the following rules:
  - (a) Chapter 0940-05-02 Licensure Administration and Procedures;
  - (b) Applicable Minimum Program Requirements for All Services and Facilities found in Chapter 0940-05-06; and
  - (c) Chapter 0940-05-35 Minimum Program Requirements for Nonresidential Office-Based Opiate Treatment Facilities.
- (2) If any provision of these rules, or the application thereof to any person or circumstance, is held invalid, such invalidity shall not affect other provisions or applications of these rules which can be given effect without the invalid provision or application, and to that end the provisions of these rules are declared severable.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.04 LICENSING PROCEDURES.**

- (1) An OBOT, as defined in 0940-05-35-.02(2)(a) and T.C.A. § 33-2-402, shall be licensed by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS or Department).
- (2) An OBOT shall include, as part of its ownership structure, 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. "Ownership Structure" means any entity, group, or individual(s) having legal ownership of the OBOT, directing its functions and operations. This includes, but is not limited to, a sole proprietor, general partner, board member of a non-profit or for-profit corporation, or managing member

(Rule 0940-05-35-.04, continued)

- of a limited liability company. Final determination as to whether ownership structure requirements for an OBOT are being met is in the sole discretion of the Department.
- (3) A public benefit non-profit/charitable corporation, registered with the Tennessee Secretary of State, shall have the Facility's medical director on its Board of Trustees.
  - (4) A corporate entity doing business as an OBOT in the State of Tennessee shall not provide, hold itself out as providing, or advertise that it provides substance use disorder treatment for opioid use disorder in the form of opioid agonist therapy, or office-based opiate treatment, unless it complies with the following requirements:
    - (a) Is appropriately registered with the Tennessee Secretary of State to operate in the State of Tennessee and/or is and remains current with corporate or non-profit/charitable registration requirements of the Tennessee Secretary of State; and,
    - (b) Includes, as a member of its Board of Trustees, the Facility's medical director.
  - (5) The OBOT shall make application with the Department's Office of Licensure by providing the following information, at a minimum:
    - (a) Application on the Office of Licensure's designated forms to include the:
      1. Initial Application;
      2. Fact Sheet; and,
      3. Financial Statement;
    - (b) Applicable fees as defined in Tennessee Administrative Procedures Rule 0940-05-02-.05;
    - (c) Evidence of a contracted and/or currently employed physician with a DATA 2000 waiver;
    - (d) Evidence of all physicians contracted and/or currently employed at the Facility holding a license from the Tennessee Board of Medical Examiners or the Tennessee Board of Osteopathic Examination;
    - (e) Comprehensive listing of all members of the organization's ownership structure; and
    - (f) Any other item the Department believes is necessary and proper for application purposes.
  - (6) Prior to renewal of the license, the OBOT shall be required to formulate policies and procedures that substantially comply with the provisions of this Rule, as well as with Administrative Chapter 0940-05-06.
  - (7) The Department may release to and/or gather information from the Tennessee Department of Health Board of Medical Examiners (BME) as is necessary for licensing and/or investigation of complaints against an OBOT.
  - (8) With or without notice, the Department, or its representatives, shall have the right to enter upon or into the premises of an OBOT in order to make inspections and/or investigations deemed necessary to determine compliance with applicable law. The OBOT shall comply with all reasonable requests of the Department and allow it to obtain information from third parties as is necessary.

(Rule 0940-05-35-.04, continued)

- (9) The Department shall be given the authority to enter upon the premises of an unlicensed facility prescribing buprenorphine-type products to better determine that unlicensed facility's need for TDMHSAS oversight. The Department shall attempt to conduct inspections and investigations in the least intrusive manner needed in order to obtain necessary information. The facility shall be required to provide reasonable amounts of information to the Department for this determination.
  - (a) "Reasonable amounts of information," in this context, may be considered aggregate, non-patient identifying information to include, but not be limited to:
    1. Patient de-identified identifiers;
    2. Lists of medications prescribed to that de-identified patient; and
    3. The total number of patients seen at the physical location in question.
- (10) The governing body of an OBOT shall designate a facility director (as defined in 0940-05-35-.02(2)(j)), who is responsible for the operation of the Facility. Non-physician facility directors shall not supervise medical staff.
  - (a) Should a Facility operate in such a fashion that the physicians working at the same physical location are unassociated and/or unaffiliated to one another in some type of business arrangement, then the unassociated and/or unrelated physicians shall designate a facility director.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.05 POLICY AND PROCEDURES.**

- (1) The governing body of the Facility shall ensure the OBOT is administered and operated in accordance with written policies and procedures in the below listed subject areas and in accordance with these rules. Each Facility shall clearly identify the governing body, as defined in Rule 0940-05-01-.01(18) and Rule 0940-05-35-.02(2)(l), in its policies and procedures manual including the name and contact information of the governing body.
  - (a) Admissions and Discharges and Best Practices Utilized (0940-05-35-.06);
  - (b) Patient Record Requirements (0940-05-35-.07);
  - (c) Patient Transfers (0940-05-35-.08);
  - (d) Individualized Treatment Plan and Best Practices Utilized (0940-05-35-.09);
  - (e) Special Populations (0940-05-35-.10);
  - (f) Counseling (0940-05-35-.11);
  - (g) Medication Management (0940-05-35-.12);
  - (h) Drug Screens (0940-05-35-.13);
  - (i) Detoxification and Medically Supervised Withdrawal (0940-05-35-.14);

(Rule 0940-05-35-.05, continued)

- (j) Diversion Control Plan (0940-05-35-.15);
- (k) Reporting Requirements (0940-05-35-.16);
- (l) Patient Rights (0940-05-35-.17);
- (m) Community Relations (0940-05-35-.18); and
- (n) Personnel and Staffing Requirements (0940-05-35-.19).

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

**0940-05-35-.06 ADMISSIONS AND DISCHARGES AND BEST PRACTICES UTILIZED.**

- (1) Initial Screening. Prior to admission to the Facility, each prospective patient shall be evaluated by the medical director or program physician and clinical staff who have been determined to be qualified by education, training, and experience to perform or coordinate the provision of such assessments. The purpose of such assessments shall be to determine, and document, 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) and whether the Facility will be the most appropriate treatment modality for the patient. No prospective patient shall be processed for admission until it has been verified that the patient meets all applicable criteria.
  - (a) The Facility shall use either standardized assessment and evaluation tools that have been peer reviewed and validated or standardized assessment and evaluation tools as approved by the Department. Examples include American Society of Addiction Medicine (ASAM) placement criteria, the Addiction Severity Index, SAMHSA's TIP 40, or any other assessment and evaluation tools approved by the Department.
- (2) Prior to receiving treatment at the Facility, the patient shall acknowledge in writing having received education on the following:
  - (a) Treatment options, including detoxification, and the benefits and risks associated with each treatment option;
  - (b) The risk of neonatal abstinence syndrome and use of voluntary long-acting reversible contraception for all female patients of child bearing age and potential;
  - (c) Prevention and treatment of chronic viral illnesses, such as HIV and hepatitis C;
  - (d) Expected therapeutic benefits and adverse effects of treatment medication;
  - (e) Risks for overdose, including drug interactions with CNS depressants, such as alcohol and benzodiazepines, and relapsing after periods of abstinence from opioids; and
  - (f) Overdose prevention and reversal agents.
- (3) A Facility shall only admit and retain patients whose known needs can be met by the Facility in accordance with its licensed program purpose and description and applicable federal and state statutes, laws, and regulations.

(Rule 0940-05-35-.06, continued)

- (4) Drug dependent pregnant females shall be given priority for admission and services.
- (5) No Facility shall provide a bounty or other reward to a third party for referral of potential patients to the clinic.
- (6) Comprehensive Assessment. Within thirty (30) days of admission, the Facility shall have completed a comprehensive assessment in accordance with peer reviewed medication assisted treatment guidelines, developed by nationally recognized organizations, such as SAMHSA and the American Society of Addiction Medicine. The comprehensive assessment shall be attached to the patient's medical chart no later than five (5) days after it is developed. It shall reflect that detoxification is an option for treatment and supported by the Facility's program and has been discussed with the patient. It shall also integrate information obtained in the initial screening. If necessary, the Facility shall obtain complete medical records from other providers with patient's written consent.
- (7) Discharge and Aftercare Plans. A Facility shall complete an individualized discharge and aftercare plan for patients who complete their course of treatment.
  - (a) All discharge and aftercare plans shall include documentation that the Facility's counseling and/or medical staff has discussed with the patient an individualized medically supervised withdrawal plan appropriate to the patient.
  - (b) The patient's discharge planning shall include the development of a menu of appropriate treatment resources available to the patient in his or her community. This menu shall be developed in consultation with the patient and shall be in writing and made available to the patient upon discharge. The Facility shall assist the patient in obtaining the appropriate referrals, as necessary.
  - (c) The discharge plan shall be completed at the time of the patient's discharge by the person who has primary responsibility for coordinating or providing for the care of the service recipient. It shall include a final assessment of the patient's status at the time of discharge and aftercare planning. If applicable, parents or guardian, or responsible persons may participate in discharge and aftercare planning. The reason for any patient not participating in discharge and aftercare planning shall be documented in the patient's record.
- (8) The Facility shall document when a patient discontinues services at an OBOT. Determination of the events that constitute a patient's discontinuation of services at an OBOT shall be at the OBOT's discretion.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.07 PATIENT RECORD REQUIREMENTS.**

- (1) Each Facility shall have a specific policy and procedure outlining the Facility's duties and responsibilities regarding any service recipient record requirements that are listed herein and in the minimum requirements of Chapter 0940-05-06.
- (2) Facilities shall organize and coordinate patient medical and billing records in a manner which demonstrates that all pertinent patient information is accessible to all appropriate staff and to TDMHSAS surveyors.



(Rule 0940-05-35-.07, continued)

- (a) Should the licensee plan to close its operations, written notice shall be given to the patient or the new provider prior to the planned closure of the Facility. Patient records shall be transferred to the patient or to the new provider within ten (10) business days of the last scheduled visit of the patient.
- (3) The Facility shall ensure that adequate billing and medical records are maintained in accordance with T.C.A. § 33-2-403(e), (f), and (g).
- (4) Except as otherwise authorized by law, no person shall be admitted for treatment without written consent from the patient and, if applicable, parent, guardian, or responsible party. A documented, voluntary, written, program-specific informed consent to treatment from each patient at admission shall include:
  - (a) Information about all treatment procedures, services, and other policies and regulation throughout the course of treatment, including clinic charges in the form of a fee agreement signed by the patient.
    - 1. This fee agreement shall include an explanation of the financial aspects of treatment and the consequences of nonpayment of required fees, including the procedures for the patient (or patient's legal representative) in the event they are unable to pay for treatment;
  - (b) Consent to the individualized, prescribed therapy before dosing begins, including information about potential interactions with and adverse reactions to other substances, including those reactions that might result from interactions and adverse reactions to alcohol, other prescribed or over-the-counter pharmacological agents, other medical procedures and food;
  - (c) Information to each patient that the goal of opioid treatment is stabilization of functioning;
  - (d) Acknowledgement that the patient has been informed of the Facility's rules regarding patient conduct and responsibilities;
  - (e) Acknowledgement that the patient has been informed of his or her rights as found in 0940-05-35-.17;
  - (f) Information that at regular intervals, in full consultation with the patient, the program shall discuss the patient's present level of functioning, course of treatment, and future goals; and
  - (g) Information that the patient may choose to withdraw from or be maintained on the medication as he or she desires unless medically contraindicated.
- (5) The patient's medical chart shall also include documentation of the following:
  - (a) Documentation that the patient's initial screening and comprehensive assessment are completed and documented in the patient's medical record prior to the development of the patient's individualized treatment plan;
  - (b) The individualized treatment plan, including any reviews, changes or amendments to the plan;
  - (c) Documentation that services listed in the individualized treatment plan are available and have been provided or offered;

(Rule 0940-05-35-.07, continued)

- (d) A record of correspondence with the patient, family members, and other individuals and a record of each referral for services and its results;
- (e) A discharge and aftercare plan pursuant to 0940-05-35-.06(7), including reasons for discharge and any referral. In the case of death, the reported cause of death shall be documented; and
- (f) Documentation of coordination of care should be present in those clinical situations which require consultations or coordination of care.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.08 PATIENT TRANSFERS.**

- (1) If a prospective patient has previously been discharged from treatment at another Facility or other type of treatment program, the admitting Facility, after having the patient sign a release of information, shall initiate an inquiry into the prospective patient's prior treatment history, inquiring of the last Facility or other type of treatment program attended and the reasons for discharge from treatment.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.09 INDIVIDUALIZED TREATMENT PLAN AND BEST PRACTICES UTILIZED.**

- (1) The admission requirements of 0940-05-35-.06 shall first be completed prior to the development of an Individualized Treatment Plan (ITP).
- (2) A Facility shall develop an ITP for each patient within thirty (30) days of admission. The ITP shall be developed in accordance with peer reviewed medication assisted treatment guidelines, developed by nationally recognized organizations, such as SAMHSA and the American Society of Addiction Medicine.
- (3) Medical care, including referral for necessary medical service, and evaluation and follow-up of patient complaints, shall be compatible with current and accepted standards of medical practice. All patients shall receive a medical evaluation at least annually and other medical examination or testing shall be considered as appropriate. All other medical procedures performed at the time of admission shall be reviewed by the medical staff on an annual basis, and all clinically indicated tests and procedures shall be repeated. The medical director or program physician shall record the results of this annual medical evaluation and review of patient medical records in each service recipient's record.
- (4) Requirements for services according to phases of treatment:
  - (a) A patient in the induction or stabilization phases of treatment shall:
    - 1. Have weekly office visits scheduled;
    - 2. Receive appropriate counseling sessions at least twice a month;
    - 3. Be subject to one (1) observed drug screen at least weekly; and

(Rule 0940-05-35-.09, continued)

4. Receive case management services weekly.
- (b) A patient in the maintenance phase of treatment for less than one (1) year shall:
1. Have a scheduled office visit at least every two (2) to four (4) weeks;
  2. Receive counseling sessions at least monthly;
  3. Be subject to a random observed drug screen at least eight (8) times annually;  
and
  4. Receive case management services at least monthly.
- (c) A patient in the maintenance phase of treatment for one (1) year or more shall:
1. Have a scheduled office visit at least every two (2) months;
  2. Receive counseling sessions at least monthly;
  3. Be subject to a random observed drug screen at least four (4) times annually; and
  4. Receive case management services at least monthly.
- (5) Each Facility shall take steps to ensure that a comprehensive range of rehabilitative services, including vocational, educational, legal, mental health, alcoholism, and social services, are made available to the patients who demonstrate a need for such services. The Facility can fulfill this responsibility by providing support services directly or by appropriate referral. Support services that are recommended and/or utilized shall be documented in the patient's record. Each Facility shall have policies for matching a patient's needs to treatment.
- (6) If the patient experiences a relapse, his or her ITP shall document evidence of intensified services provided. Such evidence may include, but is not limited to, an increase in individual or group counseling session(s) or more frequent drug screens.
- (7) A patient's ITP shall be reviewed at least every six (6) months and a discussion shall be held with the patient regarding his or her continued desire to remain in the program for maintenance treatment. Alternatives such as medically-supervised withdrawal shall be presented to the patient at the time of the discussion and documented in the patient's record. The patient shall sign and date a statement indicating that she or he wishes to remain within the program in a maintenance phase. If the patient wishes to enter medically-supervised withdrawal, the plan of care shall reflect that choice.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.10 SPECIAL POPULATIONS.**

- (1) **Pregnant Women/Women of Child Bearing Age and Potential.** Upon the initial screening, the Facility shall screen all women of child bearing age and potential for pregnancy. The Facility will ensure that pregnant women and women of child bearing age and potential shall be treated using nationally recognized best practice guidelines and within all applicable federal and state rules and regulations. If the Facility does not provide prenatal care to pregnant patients, the Facility shall ensure that there is coordination of care between the Facility and the pregnant patient's prenatal care provider.

(Rule 0940-05-35-.10, continued)

- (a) The Facility shall document, in the patient's medical record, that the Facility has informed all pregnant women and women of child bearing age and potential, initially and at regular intervals, of the risks and benefits of the utilization of voluntary, reversible, long-acting contraception, of the risks and benefits of medication assisted treatment and detoxification treatment with buprenorphine containing products, and of the risks associated with the continued use of illicit opioids, including neonatal abstinence syndrome. The information provided to pregnant women and women of child bearing age and potential shall be based on current best practices and research.
- (2) Pain Management. The Facility shall ensure that program physicians are knowledgeable in the management of opioid use disorder in a context of chronic pain and pain management. Individuals being treated with opioids for chronic or acute pain, who have become physically dependent in the course of their medical treatment, should be treated in a medical or surgical setting due to the possibility that this type of patient may need a higher dosage of pain medication to achieve adequate pain control. Individuals who are addicted to opioids, demonstrating drug-seeking behavior, or performing illegal drug-related activity, and who also need treatment for pain may be enrolled in the Facility but the Facility shall ensure continuity of care and communication between treatment programs or physicians regarding patients receiving treatment in both a non-residential office-based opiate treatment facility and a licensed pain management clinic or a pain management specialist's office for purposes of pain management, with patient consent.
- (3) Co-occurring disorders. The Facility shall ensure that patients with mental health needs are identified through the initial screening and comprehensive assessment processes and are referred to appropriate treatment.
  - (a) The Facility shall monitor patients during treatment to identify the emergence of symptoms of mental illness.
  - (b) The Facility shall establish linkages with mental health providers in the community.
- (4) Polysubstance Abuse. The Facility shall address abuse of alcohol and other non-opioid substances within the context of the medication-assisted therapy effort. Ongoing polysubstance abuse is not necessarily a reason for discharge; however, the patient may be offered a referral to more intensive levels of care, to include but not be limited to, intensive outpatient or residential alcohol and drug abuse treatment.
- (5) Criminal Justice. The Department encourages each Facility to work with local law enforcement, probation officers, and courts, including recovery (drug) courts, to act as a resource for individuals in the criminal justice system to receive the necessary treatment services including medications and counseling.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.11 COUNSELING.**

- (1) Counseling is essential and the Facility shall determine the best counseling option for each individual patient based upon the patient's history and assessments, agreement with the patient, and the goals of the patient's individualized treatment plan.
- (2) The Facility shall be responsible to determine and document that counseling is being received and the patient is progressing towards meeting the goals listed in the individualized treatment

(Rule 0940-05-35-.11, continued)

plan. The Facility shall review and modify the individualized treatment plan if it is determined that a patient is not following through with counseling referrals.

- (3) If the Facility utilizes their own staff to provide counseling:
  - (a) The Facility staff shall be sufficient in number and in training to:
    1. Allow the Facility to provide adequate:
      - (i) Psychosocial assessment;
      - (ii) Treatment planning; and
      - (iii) Individualized counseling.
    2. Allow for regularly scheduled counseling sessions; and
    3. Allow patients access to their counselor if more frequent contact is merited by need or is requested by the patient.
- (4) For Facilities referring patients for counseling, the Facility shall provide the patient, with the patient's consent, a list of available licensed treatment providers in the community and assist the patient in receiving these services by offering to make appointments on the patient's behalf and by coordinating care.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.12 MEDICATION MANAGEMENT.**

- (1) Opioid Drugs. Facilities shall develop and implement written policies and procedures for the prescription of opioid drugs. Any changes to these policies and procedures shall be done in consultation with the Facility's medical director. These policies and procedures shall include the following:
  - (a) Prescribing.
    1. The proper initial dose, medication type, and dosage form shall be based on the clinical judgement of the program physician who has examined the patient and who has considered all available relevant patient-specific information including, but not limited to, drug screens, initial screenings, medication availability and cost, and in consultation with the patient.
    2. No standardized routines or schedules of increases or decreases of medication doses may be established or used.
    3. A patient dose greater than sixteen milligrams (16mg), or its equivalent, per day shall be considered a high dose.
    4. A copy of all prescriptions written for a patient at the Facility shall be documented in the patient's medical chart.
  - (b) Protocols for initiating or switching a patient to a high dose of the treatment medication used at the facility.

(Rule 0940-05-35-.12, continued)

1. The patient's medical chart shall include documentation of rationale that it is clinically appropriate for the patient to receive a high dose of the treatment medication.
  2. The prescriber shall have a discussion with the patient and the patient shall provide written consent acknowledging that the patient will receive a high dose of the treatment medication.
    - (i) This discussion shall include dosing information to assure that the patient is using appropriate techniques for administering the particular prescribed treatment medication.
- (c) Prescriber-Initiated-and-Led Tapering Discussions
1. Prescribers shall initiate and lead a discussion with the patient regarding patient readiness to taper down or taper off treatment medications employed in the patient's treatment with each patient at any time upon the patient's request but no later than one (1) year after initiating treatment and then every six (6) months thereafter.
    - (i) Documentation of all prescriber-initiated-and-led tapering discussions shall be placed in the patient's medical chart.
  - (2) CSMD Check. The Facility shall check the CSMD upon every visit of the patient with a program physician. The patient's medical record shall include documentation of the check of the CSMD and the date upon which it occurred.
  - (3) Benzodiazepine Use. Benzodiazepines should only be prescribed to a patient after careful evaluation while utilizing caution and good judgement. Benzodiazepines may be prescribed to a patient on buprenorphine or a buprenorphine and naloxone combination under the following conditions:
    - (a) Benzodiazepines may not be initiated with a patient with opioid use disorder or the disease of addiction who has never been prescribed these products or has a history of misusing or abusing these products, except in extreme circumstances for severe anxiety or panic disorder, and only after evaluation by a board certified psychiatrist.
    - (b) Patients who present with a longstanding prescription for benzodiazepines for a legitimate medical condition from another prescriber may be prescribed buprenorphine products by a physician with a DATA 2000 waiver. Contact should be initiated with the prescriber of the benzodiazepine to coordinate care and clear documentation should be recorded in the patient's medical chart.
    - (c) A program physician at an OBOT may assume management of a patient's benzodiazepine prescribing from another physician if the patient is willing to initiate a program of tapering.
    - (d) If a patient presents at an OBOT with a dual diagnosis of opioid use disorder and a clear history of benzodiazepine use disorder, the duration and extent of the abuse should be clearly documented in the medical record. A program physician at an OBOT may prescribe a long acting benzodiazepine, such as clonazepam or its equivalent, under the following conditions:
      1. A patient may continue on benzodiazepine therapy as medically indicated as long as there is an ongoing effort to taper the patient to the lowest effective dose in

(Rule 0940-05-35-.12, continued)

order to prevent benzodiazepine withdrawal syndrome and clear documentation of this effort is made in the patient's medical record.

- (i) Prescribing more than two (2) milligrams of clonazepam or its equivalent twice daily is considered "high dose therapy".
  - (ii) Patients receiving high dose therapy should have justification for the dosing clearly documented in the patient's medical record.
  - (iii) Patients receiving high dose therapy should be tapered as rapidly as possible to two (2) milligrams or less of clonazepam or its equivalent twice daily, and if the taper is unsuccessful, the reason(s) shall be clearly documented in the patient's medical record.
  - (iv) Patients receiving high dose therapy for a period of longer than six (6) weeks shall be managed by a physician who is board certified in addiction medicine or who is board certified or fellowship trained in addiction psychiatry, or by a physician with a DATA 2000 waiver who has obtained a formal consult from a physician who is board certified in addiction medicine or who is board certified or fellowship trained in addiction psychiatry. The formal consult shall be clearly documented in the patient's medical record.
- (4) The Facility shall develop guidelines for review of prescriptions from other providers. These shall include:
- (a) Procedures to ensure that a patient's prescriptions from outside physicians will be reported to the medical staff and reviewed by the program physician at admission and annually thereafter;
  - (b) Procedures describing the Facility's response when information about prescriptions from outside physicians is not reported to ensure compliance with this rule; and,
  - (c) Documentation of the Facility's efforts to obtain information about prescriptions from outside physicians in the patient's record, if a Facility is unable to acquire information about a patient's prescriptions.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, Chapter 912 of the Public Acts of 2016, and Chapter 978 of the Public Acts of 2018. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017. Emergency rule filed December 20, 2018 to become effective January 1, 2019; effective through June 30, 2019.

#### **0940-05-35-.13 DRUG SCREENS.**

- (1) 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.
- (2) Drug screening procedures shall be individualized and shall follow the required drug screen frequency described in 0940-05-35-.09.
- (3) More frequent collection and analysis of drug samples during episodes of relapse or medically-supervised or other types of withdrawal may occur.

(Rule 0940-05-35-.13, continued)

- (4) Collection and testing shall be done in a manner that assures that samples collected from patients is unadulterated. Such collection and testing shall include random direct observation that is conducted professionally, ethically, and in a manner which respects service recipients' privacy.
- (5) A positive test is a test that results in the presence of any drug or substances that is illegal or for which the patient cannot provide a valid prescription or any drug or substance prohibited by the Facility. Any refusal to participate in a random drug test assigned by the Facility shall also be considered a positive result.
- (6) The Facility shall document both the results of toxicological tests and the follow-up therapeutic action taken in the patient record.
- (7) 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.
- (8) Nothing contained in this rule shall preclude any Facility from administering any additional drug tests it determines necessary.

**Authority:** T.C.A. §§ 4-3-1601, 4-1-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.14 DETOXIFICATION AND MEDICALLY SUPERVISED WITHDRAWAL.**

- (1) Medically supervised withdrawal occurs as a voluntary and therapeutic withdrawal agreed upon by staff and patient. In some cases, the withdrawal may be initiated against the advice of clinical staff (against medical advice).
  - (a) The Facility shall work with the patient to taper the patient's dose at a rate that is well tolerated by the patient.
  - (b) The Facility may offer supportive treatment including increased counseling sessions or referrals to a self-help group or other counseling provider as appropriate during a medically-supervised withdrawal.
  - (c) The Facility shall make provisions for continuing care (i.e. referral to other community resources for counseling, etc.) for each patient completing care at the Facility and for re-entry to the Facility if relapse occurs or if the patient should reconsider treatment at the Facility.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.15 DIVERSION CONTROL PLAN.**

- (1) Each Facility shall prepare a Diversion Control Plan that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate medical treatment use and that assigns specific responsibility to the medical and administrative staff of the Facility for carrying out the diversion control functions described in the Diversion Control Plan. These measures may include patient call backs. The Diversion Control Plan shall address, at a minimum, the following scenarios that may indicate diversion:



(Rule 0940-05-35-.15, continued)

- (a) The patient has been reported to be diverting medication.
- (b) The patient's recent drug screen results show an absence of the treatment medication.
- (c) The patient's urine drug screen is identified as not belonging to the patient or is otherwise adulterated.
- (d) Results from the patient's CSMD check demonstrate significant variation from the patient's treatment plan.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.16 REPORTING REQUIREMENTS.**

- (1) Upon request or inspection, the Facility shall submit the following information to the Department:
  - (a) All reports, forms, and correspondence submitted to or received from the health-related boards of the Tennessee Department of Health, FDA, DEA, SAMHSA or any other applicable federal agencies, or accreditation organizations shall be provided to the Office of Licensure within five (5) business days of sending or receiving such documents.
  - (b) Such reports and information which may be required by the Department to conduct evaluations of medication assisted treatment effectiveness or monitor service delivery.
- (2) The Facility shall report any significant occurrence, as defined in the TDMHSAS Office of Licensure Reportable Incident Form Instructions, to the Office of Licensure. This shall include any unexpected occurrence or accident that results in death or serious injury to a patient or any action taken against the Facility by the DEA, accrediting body, or other state (not to exclude any state related boards and/or commissions), local, or federal agency. Additional reporting requirements may be found in Chapter 0940-05-02-.20.
- (3) The Facility shall be required to respond in writing following the citation of the Office of Licensure or other State entity. The Facility will be given an appropriate amount of time to respond and their response should encapsulate at least the following:
  - (a) The actions implemented to prevent the recurrence of the event;
  - (b) The time frames for the action(s) to be implemented;
  - (c) The person(s) designated to implement and monitor the action(s); and
  - (d) The strategies for the measurements of effectiveness to be established.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.17 PATIENT RIGHTS.**

- (1) Patients shall have a right to present complaints, either orally or in writing, and to have their complaints addressed and resolved as appropriate in a timely manner.

(Rule 0940-05-35-.17, continued)

- (2) All applications, certificates, records, reports, and all legal documents, petitions and records made or information received pursuant to treatment in a Facility directly or indirectly identifying a patient shall be kept confidential in accordance with T.C.A. § 33-3-103; Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations at 45 Code of Regulations (CFR) Parts 160 and 164, Subparts A and E; and Confidentiality of Alcohol and Drug Abuse Patient Records regulations at 42 CFR Part 2.
- (3) Patients have the right to a humane treatment environment that affords reasonable protection from harm, exploitation, and coercion.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.18 COMMUNITY RELATIONS.**

- (1) The Facility shall have policies and procedures for community relations to include the following:
  - (a) The Facility shall identify Facility personnel who will function as community relations coordinators and define the goals and procedures for the community relations plan.
- (2) A Facility shall be responsible for ensuring that its patients, while on the Facility's premises, do not cause unnecessary disruption to the community or act in a manner that would constitute disorderly conduct or harassment by loitering.
- (3) Each Facility shall provide TDMHSAS, when requested, with a specific plan describing the efforts it will make to avoid disruption of the community by its patients and the actions it will take to assure responsiveness to community needs.
- (4) Each Facility shall document community relations efforts and community contacts, including the resolution of issues identified by community members or patients.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.

#### **0940-05-35-.19 PERSONNEL AND STAFFING REQUIREMENTS.**

- (1) A personnel record for each staff member of a Facility shall include an application for employment and/or resume and a record of any disciplinary action taken. A licensee shall maintain written records for each employee.
- (2) Staffing.
  - (a) Facility Director. The governing body of each Facility shall designate in writing a facility director who is responsible for the operation of the Facility and overall compliance with federal, state and local laws and regulations regarding the operation of non-residential office-based opiate treatment programs, and for all employees at the Facility. However, non-physician facility directors shall not supervise medical staff. Facilities shall notify the TDMHSAS Office of Licensure in writing within ten (10) calendar days whenever there is a change in facility director.

(Rule 0940-05-35-.19, continued)

- (b) **Medical Director.** The governing body of each Facility shall designate in writing a medical director to be responsible for the supervision of all medical staff at the Facility and the administration of all medical services at the Facility, including compliance with all federal, state, and local laws and regulations regarding the medical treatment of opioid use disorder. The medical director shall be physically present at the Facility the equivalent of twenty-five (25) percent of the time the Facility is open to the public each week. On a monthly basis, the medical director shall review ten (10) percent of the medical charts for patients currently admitted at the Facility and document each chart review. No physician may serve as medical director of more than three (3) Facilities without the prior written approval of the TDMHSAS Office of Licensure.
  - (c) **Program Physician.** Facilities are required to provide sufficient physician services to provide the medical treatment and oversight necessary to serve patient need. A Program Physician may be the same individual as the Medical Director, should the Facility so choose and all qualification requirements for a medical director are still met.
  - (d) **Physician Assistants and Advanced Practice Nurses.** Licensed physician assistants and advanced practice nurses with a certificate of fitness with privileges to write and sign prescriptions and/or issue legend drugs may perform any functions under Federal and Tennessee law or regulations.
  - (e) **Case management/care coordination.** Each Facility shall provide case management/care coordination services by a qualified provider.
- (3) **Staff Qualifications.**
- (a) **Staff Training.** Prior to working with patients, all staff providing treatment or services shall be oriented in accordance with all applicable administrative rules, reporting requirements, and their individual position responsibilities. All staff shall receive ongoing training and development activities. Record of all staff training activities shall be noted in their personnel record.
  - (b) **Medical Director.** A medical director shall be licensed to practice medicine or osteopathy in Tennessee, shall maintain an unrestricted license to practice medicine or osteopathy, hold an active DATA 2000 waiver from the DEA, be designated by the OBOT's governing body, and shall have the following experience and/or credentials:
    - 1. Certification in addiction psychiatry by the American Board of Psychiatry and Neurology or exam eligible in addiction psychiatry and two (2) years of documented experience in the treatment of persons who are addicted to alcohol or other drugs; or
    - 2. Certification as an addiction medicine specialist by the American Board of Addiction Medicine (ABAM) or exam eligible for certification as an addiction medicine specialist and two (2) years of documented experience in the treatment of persons who are addicted to alcohol or other drugs.
  - (c) **Program Physician.** A program physician shall be licensed to practice medicine or osteopathy in Tennessee, shall maintain an unrestricted license to practice medicine or osteopathy, and hold an active DATA 2000 waiver from the DEA.
  - (d) **Facility Directors.** All Facility directors shall have at least one (1) year of supervisory or administrative experience in the field of opioid use disorder treatment.
  - (e) **Qualified Provider.** A qualified provider shall be duly licensed, certified or registered as required by the State of Tennessee for the profession and shall only perform those

(Rule 0940-05-35-.19, continued)

duties that are within the scope of their applicable professional practice acts and Tennessee license.

- (4) Employee Drug Screening. Facilities shall implement pre-employment and ongoing random drug screening of all Facility employees.

**Authority:** T.C.A. §§ 4-3-1601, 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-402, 33-2-403, 33-2-404, 33-2-407, and Chapter 912 of the Public Acts of 2016. **Administrative History:** Original rules filed October 14, 2016; effective January 12, 2017.