The Intersection of DEA, Opioids and MAT

3:00 – 4:00 PM ET

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>> The registration is exactly what it looks like there. DEA also works on the quarters of certain jobs. ARCOS is a big computer system that DEA uses to track drugs across America. The record-keeping and the security requirements are really copied after the banking industry ones. You have to keep a record, and you have to have security around your drugs depending on the type of drugs. They are cyclic investigations. Congress set DEA up to go over the manufacturers or distributors every year, sometimes every three years, and inspect them for compliance with the record-keeping and security rules. That is what DEA calls the cycling investigation.

I'm going to quickly talk about DEA authority versus HHS/SAMHSA...

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They dictate the practice of medicine in partnership with (static), they also dictate what medications to be used. I will talk about that. As I mentioned again, and will probably hear a few times, DEA's authority is strictly the security of the drugs and the record-keeping requirements. DEA runs pretty much independently where they will work with agencies, but because they are primarily a law enforcement agency, they like to remain fairly independent on all their actions.

Let's talk about data waves and office-based opioid treatment. DATA stands for the Drug Abuse Treatment Act of 2000. Everybody calls it DATA, and that created Office-Based Opioid Treatment. Prior to this law in 2000, the only treatment options available was the opioid treatment programs. Some people used to call them NTPs, narcotic treatment programs, and some people still call them methadone clinics. When they created this law and Congress, it created more avenues to treat these people suffering from opioids.

Here's what it looks like. Before DEA will give out the number, you always have to have a state medical license and a state controlled license. That is kind of ground in the history of drug laws that the practice of medicine is governed by state and state medical boards. DEA's license now is $888, and it's good for three years. Once you get your MAT waiver, when you take that class for that provider, that NP, that Doctor takes that class from SAMHSA or PCSS, they get an X-number from DEA. You take the classroom SAMHSA, they notify DEA, and DEA gives them another number in addition to the regular number, that is usually referred to as a X-number.

Here's what it looks like now, and this is current if you are a medical provider. You have to take an eight hour MAT class, Medication Assistant Treatment class from SAMHSA. NPs and PAs are required to take a 24 hour class. SAMHSA, upon notification of results of the class, they notify DEA. DEA assigns an X-number, and in that first year, that provider can generally treat up to 30 patients. The next year, if they want to, they can go up to 100. For certain providers that have certain certifications or certain office space support systems, they can actually go up to 275. I will talk about these limits here in a little bit, and just last year about this time, SAMHSA created a new method where any provider can notice SAMHSA and start treating 30 patients without taking any class, but they have to go to SAMHSA first.

I have the web link for additional information on every one of my slides I do, if the viewer wants additional information.

SAMHSA has a great webpage, and I stay current by checking it. Here is the webpage link if anybody's interested on how you become a DATA waiver and how you got your X-neighbor.

PCSS is the Provider Clinical Support System. They Do Free Training around the Country for MAT. Quickly on the 275, I don't want to read everything for the sake of time, but to get to the 275 patient requirement, the provider must be bored-certified and approved by one of the specialties listed or by practicing in a qualified setting, which usually means more of a larger medical practice may be tied to a hospital. These are all SAMHSA/HHS determinations, and they often tell people, "If you have a question, email SAMHSA." They got a great website, and they supported very well.

Many of you are aware of this. The three most common drugs to treat opioid addiction of methadone, naltrexone, and then some form of buprenorphine. I will talk about differences. The big difference off the top is that only added opioid treatment program, methadone...

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That is really the big difference between buprenorphine versus methadone. Naltrexone is not a controlled substance, so anybody can provide that.

Common forms of buprenorphine are suboxone, subutex, and in the last three years, injectables and implantable.

In 1972, the first narcotic treatment programs were approved in America. More people now call them Opioid Treatment Programs. Nobody really calls them "Narcotic treatments". I mentioned earlier, they are usually open from 6 AM to 2 PM, and they can do methadone or suboxone depending on what they believe or what the patient needs. They are highly regulated, and they also have built in counselors.

This is some quick photos. It looks somewhat like a bank teller window where the patient goes up to the window and the nurse dispenses.

To get an OTP license, hope your treatment program license, one first need state approval followed by SAMHSA, and the DEA license and registration is the last step. DEA, again, as I mentioned earlier, they are only dealing with the security. If anybody has been inside a methadone clinic, they actually have a big safe and actually have to store the methadone clinic -- methadone in, and that is required by federal law.

Here are the differences between the two, because they both treat the patient's needing opioid use disorder treatment. The DATA waived docs, all you have to do is get SAMHSA. The patients are either (indiscernible). NP's are not allowed to dispense or describe methadone. They are allowed to dispense or prescribe buprenorphine products. It generally depends on the practice. I have seen it both ways across the country. Some have counselors on site, some don't. The guidelines seem to be quite a bit more flexible than the OTP programs.

On the right column, the OTP programs, federally, state, and SAMHSA approved. There are no patient limits on an OTP. They can dispense either methadone or buprenorphine. Counselors are on-site with fairly rigid guidelines about...

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Nationwide, here is what the numbers look like...

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2000 OTP's across the country. This has jumped up across the past three years in response to the opioid epidemic. It used to be around 1500.

>> Denis, sorry, you keep freezing, so we missed this slide that you are on. I think maybe we can try if I share the slides from my computer and you remote in, and we can see if that might work better?

>> What you want me to do? Stop...?

>> Hold on, I'm going to do it for you. Hold on one second. Give me one second. One more... Second... You should have remote control of the slides on my screen now. Actually, let me turn my video off. You can just take the mouse and click anywhere on the slide, and that will tell Zoom that you are controlling the slides, and then you can click or use the mouse to go through your slides.

>> OK, we are good. Thank you, Jessie. OK, guys, back to it. Here are the latest numbers on the registrants. Overall, 1,360,000 doctors, the MPs and the PAs who can do (indiscernible) are a little under half a million. There are 18,000 hospitals. Kind of giving you the lay of the land of family DEA registrants there are. This number grows by 5-6%.

We are going to talk about CARA, the Comprehensive Addiction and Recovery Act, passed in 2016 by Congress. It has also been updated. We are going to hit some of the highlights.

It went into effect in mid-2016. It raised the patient limits up to 275. It used to be at 100, and then it also allowed nurse providers and PA's to actually treat, too, those suffering from OUD. Prior to that, you had to be an MD or a DO. At the same time, SAMHSA updated their guidelines and published (indiscernible) in early 18, and these are kind of the numbers to show you who is doing what. 71% % of the providers out there currently are staying at the 30 patient limit. 22% are at 100. 7% are at that highest cap of 275.

Who decides the patient limits? I wanted to touch on that because that is usually a question I get quite a bit. When Congress passed CARA, they told SAMHSA and HHS to come up with the new regulations. The link I have at the bottom of the slide is if you want to learn more. What happens is that HHS made new regulations, and they had to let it out to the public and to comments. The next few slides I have are actually comments and explanations why they made the decisions they did.

HHS and SAMHSA were originally going to hold it at 200, but some new people wrote in that they moved it to 275. They are the ones that hold and decide the limits. It has never been DEA. DEA has no authority on the limits.

They received a number of comments. I'm going to talk a little bit later about DEA's involvement back in the history of MAT, but there is some historical fear about their inspections. I will tell you what in a little bit. They had other concerns about insurance requirements and documentation, etc.

DEA is a big supporter. Keep in mind, I'm retired at the very beginning of 2018. DEA is a big supporter of MAT, and even though I have been gone for five years, I know they still are.

Here are the other highlights. Besides the 275, the thought process behind HHS in that second bullet was they felt going above that wasn't giving the patient care that they thought needed for these types of patients. I often hear a number of people's income "You shouldn't even have a patient cap." I hear that argument. I understand it. That cap has been decided by HHS.

I might have gotten ahead of myself. In this one, the second bullet on this slide again, here are some more reasonings by HHS on their thought process and why they wanted to keep that cap at 275.

Now, for my days when I was working at DEA, I read a number of (indiscernible) pain providers, MAT at a number of conferences, and was asked many questions. These are anecdotal things I have learned as a former DEA agent why some people don't want to become MAT providers. Out of all the doctors in America, and peace, and DA's , only buttocks percent – and this number is held true for a couple of years – have the MAT waiver. Only about half use that waiver, so about 3%. Some of the doctors said they don't like the patient base, don't have the counseling support they believed they needed, some don't believe in replacing 10. For another, and it is time consuming and the treatment is difficult. These are all reasons. I'm not saying there are good reasons, but these are the ones I have heard in my days out in the field.

There are three real MAT guidelines. The most current is the latest one, the SAMHSA TIP 63. It initially came out in February 2018. SAMHSA updated it in June 2021. It was preceded by TIP 40.

A couple key things I want to bring up to you. In TIP 63, SAMHSA: "the law requires buprenorphine providers to be able to refer patients to take OUD medication. These providers can beat this requirement by keeping the list of referrals or providing counseling themselves." All they have to do is refer. It's not mandate.

And then the other good... No, I missed that. My apology. The other big thing that has changed or came out as most doctors nowadays prescribed to prepare an orphan and do induction in the office. When buprenorphine came up in the mid-2000, many doctors There buprenorphine in their office and inducted that way. Most doctors now — and it's a smart way and cuts provider risk, keeping that prescribed to that patient, inducting them, and watching them. It save you a bunch of time and a bunch of DEA paperwork.

Another good thing about the SAMHSA guidelines is I believe there are about 350 pages long. They have the latest forms in them if anybody needs them or wants to update their forms in their office.

A little-known fact: this law has been in place for over 50 years. The hospital provider without a DEA number can actually administer methadone or buprenorphine for a three day period the patient. My belief is when the lawmakers made this rule 50 years ago, they wanted to help that person during those weekend periods when that doctor could refer that patient to an addiction specialist for treatment on Monday.

Let's talk about the DEA MAT inspections. When they first made DATA 2000, as I mentioned earlier, is kept in line with DEA's authority. DEA is authorized to actually conduct inspections of providers or any registrant that actually stores drugs, and I had mentioned just a few minutes ago, back when they started buprenorphine, doctors would keep it in their office to induct the patients. By keeping those drugs in their office, that allowed the DEA to inspect the records for that office.

This in turn scared the heck out of a lot of doctors. DEA was only looking at the records. They weren't opining on how much dosage or how long or any medical care, but it's all about the records in the DEA's eyes. As you can see, this scared a lot of doctors back in the 2000s, so doctors still talk about it today. It is my understanding that the DEA hasn't done these types of inspections in several years. The fear is still out there by some.

I just mentioned this. This is the history, if you want to know a little bit more. I tell my clients: "I prescribed. My patient comes back with a start, induct them, and will be fine. You don't really have to keep any records except your normal medical records that you keep in your file."

So, what are the criteria? Let's say you do have an office where you keep drugs in stock. The DEA's focus will be nothing but the drugs. That's what it is. They are going to try to account for what comes in and where it goes. They might check on your patient limits. And most of the times, if there is a violation, it's like a warning/speeding ticket. You have to keep federal records and things like that.

As I just mentioned a little bit ago, the smartest thing is don't keep drugs in your office. Prescribed only if you are prescribing buprenorphine products.

These are the required records, and if one were to keep drugs, the key is to really keep an inventory. Keep all your invoices together. There is a two year look back, and you have to keep your dispensing records. Those are really the records center provider would keep. The other records pretty much apply mostly to pharmacies. Really have to keep these records every two years.

Here is what the audit process would look like if the DEA were to show up at a providers office. It would be a couple, 2-4 investigators, and be a 2-4 our process. You have the right to refuse an inspection, but the law is also written that the DEA has the authority to give an administrative-type word. The records need to be readily retrievable. And again, it's just your controlled substance records. If you don't keep controlled substance records, they will probably never show up.

This is the audit form DEA uses. It's just a typical accounting form. They are just trying to match up the numbers you have on hand with your records. That is what they are trying to match up. Same thing you do with your check register at home.

I mentioned this just seconds ago, but if you do keep buprenorphine products in your MAT office, those records have to be kept for two years. You have to do an inventory every two years, and you have to have a dispensing log where all the drugs should be locked up in a cabinet, and you should limit access, and he would be fine in one of these inspections.

There is a great manual out there if you work at an OTP. My standing is the DEA is updating it. I've got the link, but this is actually the manual for, at least from the DEA side, and OTP, and it lists all the requirements you must keep to run your OTP, at least from a DEA standpoint. It has nothing to do with the medical practice side.

OK, you want to know more? Go back to SAMHSA. Great webpage. This is one of the reasons I mentioned that new regulation by SAMHSA that allows providers to treat up to 30 people without going

through the SAMHSA class. They want to know where those providers are so they can help those patients find it. In your webpage, there is a quick search by ZIP Code for MAT providers.

They also do OTP's by state. Somebody can find it on SAMHSA's website. They also do it on behavioral health treatment websites by state as well. SAMHSA runs a great website for treatment.

This is their main page.

This is their main DATA waived page. If you want to know any additional information on the DEA side.

Quickly, let's morph into here as we start closing up to get ready for those questions. Most commonly abused drugs... DEA runs a national computer system. They call it NFLIS, and that stands for the National Forensic Laboratory Information System. In effect, you have around 90% of the world's or nation's drug crime labs reporting information to DEA, and then they total and tallied up and spit it back out so everybody can see the trends. Here is what the latest trends are.

Top seized opioids. Of course, we all know it is fentanyl. That's primarily the fentanyl from China and Mexico. Followed by that is oxycodone and then buprenorphine and hydrocodone.

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Oh, we got ahead of ourselves again! Bear with me. OK, the benzos. Xanax is always the number one benzo found on the street.

I'm going to walk you through some MAT case studies, because I get a lot of questions on these too. DEA... It's really the way the laws are set up. DEA can do either an administrative type case. That's a licensing-type of issue. Sometimes, it's a civil case. It is usually civil fines were some tickets penalized. Some cases are criminal. Most providers' self abuse cases are strictly administrative and are handled by the state. DEA generally doesn't even get involved in this. A civil case is usually against a pharmacy or manufacturer or some sort of record keeping issue, and those fines can be quite substantial. Criminal cases deal with pill mills and doctors doing things out of the ordinary. We have a few examples.

But before I get any examples, this is the definition of a legitimate prescription. This is really the basis that DEA looks at when they are looking at a provider that might have done something unlawfully. In this login, 50 years old, but a prescription must be issued for legitimate medical purposes in the normal course of a professional practice. It gives a provider wide latitude to practice medicine. The law also says that part B, all prescriptions shall be dated and signed on the date when issued. Those are two components, and would give you some examples and kind of flesh out the examples, because I often get asked those.

These are photos of an MAT office. A few years ago, they got in trouble with DEA. It was pretty wild, actually.

OK, here are a couple examples. Here is a civil fine case out of Boston a few years ago. This Doctor had to pay the government, I think in this case... What was it? $23,000. If you look at this bottom lid, this is where the doctor got in trouble. He told another doctor to sign hundreds of blank prescription pads while they were both out of the office or abroad, and they actually had nonphysician staff who handed out 600 prescriptions, and in the actually billed Medicare.

In this case, that's a big no. Cases like this are actually charged criminally. This case, he was just civally fined by the government.

Here's another case in Syracuse, New York. He had a physician accept marijuana in exchange for Suboxone prescriptions. His records weren't up-to-date. That's not usually a DEA issue, but sometimes they will tie that into the records. The real issue with what this guy was doing was trading marijuana for Suboxone prescriptions, and that is clearly outside of medical practice.

Here is a criminal charge out of Albany where a doctor/psychiatrist was also doing buprenorphine and Xanax and Adderall and wasn't doing it the proper way. In one instance, the government charged him when he exchanged prescription drugs in exchange for sex. That's an example I use when people ask for an example outside of those bounds.

Here's the last criminal example. This was in Pennsylvania. There were doctors, again, pre-signing a bunch of blank prescriptions for buprenorphine. They wanted the office. Nobody was really looking at the patient and going through their charts or figuring out their treatment plan. You had unsupervised staff handing out pre-signed prescriptions, and then they were billing Medicare and Medicaid for those services. That's a very common one, but the amount of people who actually get in trouble by federal law enforcement or the state firm is prescribing buprenorphine is very low. It's usually well under 1/10th.

Here are some common OBOT problems I have seen from around the country. Whenever the problem is the non-provider is the owner and manager, they will usually do some things they regret. Anytime they have access to the prescription pad, it's like the same outcome if we were going to leave our checkbook lying around in an office with people. Cash only practices always bring attention. A regular business hours – I have seen someplace is open until 1 or 2 AM. And in other times, other providers or patients or pharmacies will call local law enforcement on the provider because they don't think their son, daughter, or friend is getting the care they need.

OTP problems. Usually in my experience, it is poor record-keeping. They are keeping good records. DEA generally will visit and OTP every 3-5 years just to check the records, and every now and then, they don't secure the medication right or they don't attest to their alarms, and these are all components that run in a good OTP.

What about urine drug screens? There is no federal law on urine drug screens. Pain providers use urine drug screens, and so do MAT providers. It's a big gray area, and my advice on that one is to follow the best guideline available. I point my people back to SAMHSA, TIP 63, etc.

What to do on a positive or negative screen is always troublesome, and I feel for the providers that have to make those decisions.

Let's talk quickly about an orphan diversion. Maryland in 2016 stopped allowing Suboxone strips, and it was mainly because the jails and prisons were finding so many smuggling it in.

Here's what it actually looks like. Because the Suboxone is in a film form, it does make it fairly easy to smuggle into a prison either hidden behind a stamp or melted into, like, a crayon drawing or something like that. They get very inventive. The Suboxone film lends itself at least prison smuggling.

Same thing they saw in Columbus, Ohio. Those strips inside of prisons are worth about $100 per strip. And as a result of these, number of states in the last few years have actually implemented MAT laws. They would have the MAT providers register, and they wanted to see some oversight and get away from these cash only businesses.

What else should I know? Telemedicine. I know this has probably affected you all in your daily practice now with COVID. All of the rules were stayed, as I call it, and I hear from a number of people that they are hoping they continue. Ryan Haight was a young man who overdosed and died from some internet-order hydrocodone in 2000, and Congress made the Ryan Haight Act in 2008, and that required that a provider have at least one face-to-face visit with the provider before going to telemedicine. This kind of

pushed DEA right in the middle of telemedicine. Before, DEA had never really been involved in telemedicine.

This is definitely an evolving issue. My advice, if anybody has questions, look at your state first on this. This is an area that DEA really never wanted to get into, but Congress pushed them into this because of the internet abuse in the 2000s, but it's definitely a fast moving target and remains to be seen how much telemedicine is going to change in the next few years. It's very involved.

What is Kratom? I'm sure you talk about this in your practices. It is a Southeast Asian plant, over-the-counter. In low doses, it's a stimulant. In high doses, it has an opiate effect, and many people self treat their pain. There have been a number of that affects from it too and a number of deaths. It is so uncontrolled right now.

Federal farm bills came out in the last years, and in essence, defines CBD and can Avenue it's as a component of marijuana. Under 3/10 of 1%, it is no longer federally controlled. So, CBD under 3/10 of 1% is not a controlled substance, and the DEA has no authority over that. Anything over it, the DEA would come and I can tell you it's not (indiscernible) of the DEA. You can buy every type of CBD now over-the-counter.

The other big change in the last several years is from Boston. They call it Police Assisted Recovery Initiative, PAARI. About 600 law enforcement agencies. It's a great thing, law enforcement partnering with treatment organizations for the person who needs treatment. They would come to the police station. The police station would take them. It's all voluntary. Then, range treatment in that opportune time when that person says, "Hey, I have hit rock bottom. I need help." It's just a great program.

To wrap it up, let's close this out. Any of you that have close friends who are MAT providers, my best advice here is to follow general and accepted guidelines. Stick with SAMHSA. I believe in counseling, but you have to have a referral link. Practice your due diligence. Then, use your prescription monitoring program. Use your urine drug screens to make best decisions. Whenever possible, describe your buprenorphine and induct them in your office. Don't keep them in your office.

As far as OTP, it's all about the records and then OTP. You have to keep meticulous records. I would always advise people to assign one person as the DEA point of contact and the keeper of the records. Never forget to do your inventories. You only have to do it every other year. I suggest every year. Then, keep your medical personnel lists who have access to the medication up-to-date.

Lastly, I'm going to hit these really quick. Then, I'm going to turn it back to Jessie for the Q&A. I often get asked questions, and these are the most common FAQs I get asked, even when I worked at DEA.

Number one was always: why is marijuana still a schedule 1 drug? Because the FDA has determined it's not medicine. There is a whole process the FDA goes through. They have been improving our drugs for over 100 years, but they have never allowed any smoked drug to be a medicine. When they have never approved it prior to being a drug, it forces DEA to put it in the schedule 1 status. All these rules and what is called these "flowcharts" are delineated by Congress, but again, marijuana is still schedule 1 pursuant to all the federal rules and policies because the FDA has determined it's not medicine. Therefore, it goes to DEA. DEA places it on the schedule, and the only schedule they can put it in is a schedule 1.

We all know that heroin and fentanyl are many times more deadly than marijuana, but there is a reason for it, and I have a link at the bottom for those who are interested.

I often get asked, why are some new people incarcerated for drug possession? I have the link at the bottom. Federally, it is less than 2/10 of 1%. These numbers are 2012, and they are still up on the internet now. They were listed under President Obama's webpage. Again, if you talk with any cops out there, they want to see the people with possession moved into treatment or diverted. Nobody wants to incarcerate those people. They haven't for a number of years.

Lastly, drug courts and counselors and treatment are very important. I often get told that there are not enough of those. Drug courts continue to grow in America. I've got the link therefore the latest stats, but there are just a whole bunch operating, and everybody (indiscernible).

With that said, if anybody has any questions, and plan to turn it back over to you, Jessie. I hope we are right on time for that Q&A.

>> Alright, we do have a lot of questions. Go ahead, guys. If you want to go through the questions and there are any that you like, you can go ahead and answer them, or you can write your own.

The first one is... Let me stop sharing so we can see you better. This is from Christine, who asked, "Could you talk about DEA's relationship with pharmacies? We are hearing pharmacies they want to fill Suboxone prescriptions due to the maximum allotment from drug wholesalers and DEA oversight."

>> You bet. Some of the asked me that same question just a couple weeks ago in a conference. DEA has a good relationship with the pharmacies and the pharmacy associations. DEA can at any time inspect those. I think what we are seeing her, and I don't have the good answers, but the same manufacturers and distributors that supply the buprenorphine to the pharmacies are the same as getting sued across America, and it's impacting their decision-making and their processes. That's the best way I can answer it. We are seeing these same businesses within these huge lawsuits across the country for prescribing or overfilling pharmacies, now they have clamped down, and I have heard this from a number of people, and it is resulting that the pharmacies aren't as comfortable filling all the scripts they might have been.

Thus the best way I can answer that, but it's kind of a rock and a hard place with that right now.

>> (Indiscernible)...

>> Jessie, you're muted.

>> Sorry, are jails eligible to obtain an OTP license? If so, what are the steps to do so?

>> I don't know about jails. I know a number of jails are doing MAT, but I really have to defer on SAMHSA for that one. The OTP's need the state approval first, and then SAMHSA. I think the question may be MAT, but kind of out of my expertise. That's really a SAMHSA there. I know they want more MAT ingest, and I have heard a number of jails are doing that.

>> This is a question from Kristin who asks: can you comment on the disconnect between prescription drug wholesalers, pharmacists, and the DEA? Sounds like the other question: what are the DEA's ongoing initiatives to increase access to MAT?

>> That one kind of goes back to that first question. It's like, that's when I think you have to get your Association to sit down with DEA. Congress has these regulations out there. All the manufacturers and distributors are in these lawsuits, but the issue is they are overfilling too many drugs, and you are seeing a clampdown to show their due diligence now, and as a result, it's affecting the MAT providers and the people needing MAT. I have heard this from a number of people. I wish I had a better answer than that, Jessie, but it's a tough spot to be in right now.

>> What is the definition of treating 30 or 100 patients? How does the DEA quantify this? Is it per prescription? Per month? Per year?

>> The DEA doesn't quantify that. That's SAMHSA. I have been asked that. I would really defer SAMHSA, but my understanding is you are capped at 30 or 100 patients, and that is what they say on the SAMHSA webpage and things like that. If you are 30 and somebody drops out, you can replace that person. If you are filling in for somebody else that's at 30, you probably don't have a problem, but those questions, if you want a definition and you want it in black-and-white, you should email SAMHSA. They've got a great email site.

To me, it's just what it is. Black and white. 30 patients.

>> If someone in jail is prescribed seven days worth of buprenorphine then released after two days, does the DEA regulate or provide guidance on whether the jail must provide the patient with their five remaining doses to take with them upon release?

>> They are allowed to do partial filling at some pharmacies. I gets a little complicated, but that DEA... That would not be a focus at DEA. That would be one for the Association in that state or the medical board. They would be a better answer if somebody is concerned about that.

>> OK. I don't know if you know this. This might also be SAMHSA. Our client and patient still required to attend counseling at least once per month while receiving MAT?

>> In my one slide, all that recommendation of SAMHSA and their guidance, all the provider has to do is show that they referred that patient to counseling. Now, I know the former guidelines several years ago, the standard was one hour per month. I don't know if that has changed, so I would go to SAMHSA. I don't know whether there is that requirement anymore, and that is why some of this area is great and evolving.

>> This is from Erin: could a residential treatment program that is not an OTP maintain a patient on methadone that the patient is prescribed/brings in from another OTP/NTP provider? In other words, the residential treatment program would be storing and administering the methadone but not prescribing.

>> That's highly technical.

(Laughter)

That's alright. These are all great questions. I would lean towards probably not. Would anybody really care? Probably not. But if you really want to know the answer, that would be one email the DATA waive page at SAMHSA, because the only ones allowed to do it are those OTP's. Any provider can do it for pain-prescribed methadone. That's totally different. But in that case, I don't think it a high-risk situation, but if you want a black and white, I would send an email right to SAMHSA and ask them.

>> One more question, let's see... I'm trying to find one that's going to be... Are there any... Let's see... Given some states' ability to prescribe medical cannabis, has there been any discussion around DEA about changing the scheduling of cannabis?

>> Only from what I know in the news, and I know Congress is looking at it and there was a bill and things like that. I know it's troublesome for providers, especially MAT providers of patients that are smoking marijuana and on OUD meds. I don't have a clean answer, especially with all the state laws on that.

Any change by DEA would be dictated by Congress and the laws. That's the thing: DEA is from merely a law enforcement agency. They don't make laws. They do make regulations, but until Congress changes the law, they cannot promulgate any regulations.

I wish I had an answer on that one, but that's a tough one, and I can't foresee the future.

>> Right. Well, Dennis, we are out of time. Friends, we are out of time, but we do actually send the questions that we don't get to to our presenters to give them a chance to take answers, and that we post them on the webpage where everyone registered for the webinar. You can jump back in a couple weeks and see if your questions were answered!

Thank you, Dennis. I'm going to just wrap up with our last little announcements here. Just a reminder that the CE quiz will be active once this is over, and you can find a link to the quiz on the webpage where you registered for this webinar. If you have any issues, try using the instructions guide. There is a link to that as well on the webpage, and if you continue to have issues, feel free to email us at CE@NAADAC.org.

Reminder that if you need the certificate to say "live" on it, which some licensure bodies require, then please take the quiz in the next 24 hours and downloaded as well.

Alright, so coming up, some exciting webinars. On May 4, we have 'Do's, Don'ts, and How To's'. On May 6, we have 'Women in Recovery Specialty Online Training Services Tough', May 11 Is 'Effective Treatment for Survivors of Intimate Partner Violence', and then May 20 is what I think is the last in our women in recovery series. Please remember to join us for those.

Just a reminder for our specialty online training series. We have five that we have made previously. One is advances in technology, wellness and recovery, ethics, clinical supervision, and addiction treatment in military and veteran culture. Each series consists of about 6-7 webinars on one particular topic, and upon completion of all the webinars in each respective treatment seminar, you can apply for a certificate for your accomplishments.

We added a women series, as I just mentioned, and we are having adolescent treatment and recovery developed in July. Stay tuned for that.

I think I just spoke about this come about upcoming month, but women in recovery. We have the final two coming up. Part five and part six are in the next three weeks. Please join us for those.

Lastly, as a NAADAC member, here is a quick reminder of all our benefits. My personal favorite is the available CE's that you can get for free as a member. There are a lot of requirements. Have the muscle for my licensure to get continuing education, and it is great to be able to pay a nominal fee, and then you get access to over 120 CE's that are inclusive as part of our member benefits. Consider joining if you are not.

Finally, a short survey will pop up at the end. Please take the time to give us feedback, share any notes represent her, and tell us how we can continue to improve your learning experience. Thank you again for participating in this webinar. Thank you, Dennis, for being here with us. Stay connected with us on social media.

I hope everyone has a wonderful day and rest of your week. Take care.