Medication for Opioid Use Disorder (MOUD) and Medication-Assisted Treatment (MAT) Provider Guidance: Expectations and Responsibilities

I. Purpose

This document outlines expectations for LSFHS Network Service Providers delivering medications for opioid use disorder (MOUD) and other medication-assisted treatment (MAT) Services, office-based treatment programs, mobile units, and opioid treatment programs (OTPs). Because MOUD/MAT services are delivered across a variety of settings, certain requirements may apply only to specific program types. Providers remain responsible for complying with all applicable federal and state laws, regulations, contractual requirements, and service-specific standards.

This guidance is intended to clarify expectations, establish minimum standards where additional direction is needed, and promote consistency in MOUD/MAT service delivery. In developing this guidance, LSFHS considered applicable laws, regulations, contractual requirements, SAMHSA TIP 63: Medications for Opioid Use Disorder, ASAM guidance, and other recognized evidence-based practices. Providers operating an Opioid Treatment Program (OTP) or providing methadone treatment must comply with all applicable OTP-specific federal and state requirements. Where OTP-specific requirements exceed the standards contained in this guidance, the more stringent requirement shall apply.

All timeframes contained in this document represent minimum standards. Providers must exercise clinical judgment and implement more frequent assessments, monitoring activities, treatment plan reviews, toxicology testing, overdose prevention interventions, or other services whenever clinically indicated based on the needs of the individual served.

II. Clinical Expectations

Intake and Assessment

A comprehensive intake assessment must be completed prior to initiating MOUD/MAT. The assessment must consider substance use history, medical and mental health status, psychosocial factors, co-occurring medical conditions, pregnancy status for individuals of childbearing potential, and the need for referrals or care coordination related to primary care, infectious disease screening, or other medical services when clinically indicated.

Documentation of informed consent for all medications, including risks, benefits, and alternatives, must be completed upon intake, whenever a medication is initiated or changed, and reviewed or renewed at least annually. An overdose prevention assessment and overdose prevention plan must be completed at intake and incorporated into treatment planning.

Comprehensive reassessments must be completed at least annually and include evaluation of treatment progress, recovery goals, ongoing medical necessity, continued benefit of treatment, and the appropriateness of continued maintenance treatment, medication adjustment, dosage reduction, or voluntary tapering/withdrawal planning.

Treatment Planning

An initial treatment plan shall be established upon admission or placement into MOUD/MAT services to address immediate treatment needs, medication services, overdose prevention needs, and urgent referrals or care coordination needs. A comprehensive individualized treatment plan shall be completed within thirty (30) days of admission. Treatment plans must outline medications, counseling and recovery

support services, individualized goals and objectives, type and frequency of services, target dates for goal achievement, overdose prevention activities, referrals and care coordination efforts.

Providers should encourage participation in counseling and recovery support services as part of a comprehensive recovery-oriented approach to care. Acceptance, participation, refusal, and follow-up efforts related to counseling, recovery support services, or medication services must be documented.

For pregnant individuals, treatment plans must include prenatal counseling and referrals when applicable. Treatment plans must be reviewed every ninety (90) days during the first year of treatment and every six (6) months thereafter unless more frequent updates are clinically indicated.

Treatment plans must be signed and dated by the individual and the person providing the service. If completed by someone other than a Qualified Professional, the treatment plan must be reviewed, countersigned, and dated by a Qualified Professional within ten (10) calendar days.

Clinical Monitoring

Monitoring begins at treatment initiation and continues throughout the course of care. Ongoing monitoring should include assessment of treatment adherence, medication effectiveness, cravings, withdrawal symptoms, continued substance use, overdose risk, toxicology results, treatment response, and recovery support needs. Changes to treatment, including medication adjustments, prescription duration, monitoring frequency, service intensity, or other treatment modifications, must be clinically justified and documented.

Providers shall review the Florida Prescription Drug Monitoring Program (E-FORCSE) in accordance with applicable laws and regulations, and whenever clinically indicated. Any clinically significant findings and corresponding actions shall be documented in the medical record. When clinical concerns are identified, including but not limited to positive toxicology results, relapse, overdose events, missed appointments, medication-related concerns, suspected diversion, co-occurring mental health conditions, or other significant clinical issues, providers shall document as appropriate assessment findings, interventions, referrals, care coordination activities, treatment plan modifications, and follow-up actions. Toxicology testing shall be conducted in accordance with applicable federal and state requirements, program policy, and clinical need. Testing should be used as a therapeutic and clinical tool to support treatment planning and ongoing assessment rather than as a punitive measure. The rationale for toxicology testing frequency and any resulting treatment modifications must be documented.

Overdose Prevention Planning and Naloxone Education

Providers shall incorporate overdose prevention education throughout the course of treatment. The overdose prevention plan shall be reviewed and updated whenever clinically indicated, including following return to use, positive toxicology results, non-fatal overdose events, significant changes in substance use patterns, medication changes, treatment interruptions, or the identification of elevated overdose risk.

Overdose prevention education should address overdose risk factors, recognition of overdose symptoms, fentanyl and other synthetic opioid risks, polysubstance use risks, reduced tolerance following periods of abstinence, emergency response procedures, and the availability and use of naloxone.

Naloxone education and access shall be offered and documented at intake, periodically throughout treatment, when elevated overdose risk is identified, following clinically significant positive toxicology results, following an overdose event, and prior to discharge whenever possible.

Documentation related to naloxone education and access must include the education provided, the date offered, whether naloxone was accepted or declined, any naloxone dispensed, prescribed, or referred, and follow-up efforts when naloxone is declined.

Providers may refer to SAMHSA TIP 63: Medications for Opioid Use Disorder for examples of overdose prevention plans, relapse prevention strategies, overdose risk reduction counseling, and naloxone education practices.

Pregnancy Considerations

Pregnant individuals require enhanced monitoring and support. When pregnancy is identified or reported, a prenatal assessment should be completed that addresses prenatal care status, substance use and treatment needs, co-occurring medical or behavioral health concerns, current medications, and referral or care coordination needs. Referrals to prenatal care shall be documented, and medication risk-benefit counseling and medication management adjustments shall be provided as clinically appropriate. Monitoring, care coordination, and follow-up activities shall continue throughout pregnancy to support treatment engagement and maternal health.

Discharge and Transition Planning

Discharge and transition planning shall begin at admission and be updated throughout treatment. Planning should address continuation of medication treatment when appropriate, overdose prevention education, naloxone access, recovery support services, referrals to ongoing treatment providers, coordination with receiving providers, and follow-up recommendations.

Individuals receiving MOUD/MAT services should not be discharged solely due to continued substance use, positive toxicology results, or relapse.

Efforts to re-engage individuals who become disengaged from treatment should be documented. Providers shall establish written procedures regarding discharge due to non-engagement, including outreach attempts, timeframes, and transition planning. Administrative discharge decisions must be clinically justified and documented.

Individuals with no contact or engagement in services for ninety (90) consecutive days should be reviewed for discharge unless there is documented justification for maintaining an open episode of care.

A discharge summary shall document treatment participation, reason for discharge, referrals provided, transition recommendations, and continuity-of-care efforts.

III. Administrative Expectations

Policies and Procedures

Providers must develop and maintain written policies and procedures covering all aspects of MOUD/MAT delivery. Policies should address medication management, medication storage and security, diversion prevention, counseling and recovery support services, toxicology testing, overdose prevention planning, naloxone education and access, discharge procedure, care coordination and confidentiality protections.

Staff Training and Competency

Staff training, competency development, and competency evaluations shall occur on an ongoing basis to support high-quality service delivery. Training should be appropriate to staff role and responsibilities and may include topics such as medications for opioid use disorder (MOUD), overdose prevention and naloxone, diversion prevention, toxicology testing, trauma-informed care, co-occurring mental health

conditions, confidentiality requirements, care coordination, documentation standards, and culturally responsive and recovery-oriented practices.

Resources:

How to become an Accredited and Certified Opioid Treatment Program (OTP)

https://www.samhsa.gov/substance-use/treatment/opioid-treatment-program/become-otp?utm_

Florida's PDMP Educational Outreach Guide for Prescribing Opioids Safely

https://duval.floridahealth.gov/programs-and-services/preventoverdoseduval/pdmp_guide_florida_od2a_duval_county_web.pdf

Florida Statute Chapter 893 DRUG ABUSE PREVENTION AND CONTROL

https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0800-0899/0893/Sections/0893.055.html

Waiver Elimination (MAT Act)

https://www.samhsa.gov/substance-use/treatment/statutes-regulations-guidelines/mat-act

Buprenorphine Telemedicine Prescribing: Questions and Answers

https://www.samhsa.gov/substance-use/treatment/statutes-regulations-guidelines/buprenorphine-telemedicine-prescribing

Bup Quick Start Guide

https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

TIP 63

https://library.samhsa.gov/sites/default/files/pep21-02-01-002.pdf

STATE PDMP PROFILES AND CONTACTS

https://www.pdmpassist.org/State

Office Based Opioid Minimal Requirements and best practices

https://pcssnow.org/wp-content/uploads/2024/12/Best-Practice-Office-Based-MOUD_2024.pdf

ASAM Pocket Guide

https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-pocketguide.pdf