A Tool for Buprenorphine Care

(A series of monthly newsletters about buprenorphine treatment)

Volume 6 Issue 1—January 2012

BIV
Buprenorphine Initiative in the VA

DEA Visits and Prescription Limits

Buprenorphine providers are slated for a DEA visit at some point every three years. In an office-based practice, the primary concern of the DEA agent is whether you are keeping to your prescription limit of 30 patients, or 100 patients with the waiver.

This issue is particularly relevant for those providers who are the primary prescriber at their clinic and who utilize covering physicians. If you are waivered for the 100 patient limit, but the prescribing limit of your covering physicians does not total at least 100, this will raise concerns during your DEA visit. From the DEA's perspective, if you are unable to resume your coverage and your covering physicians are not able to take on your caseload, you are in violation.

For example, you are a physician with the 100 patient limit and you have 58 patients in your clinic. You have two covering physicians, each with the 30 patient limit. In this scenario, the DEA agent will insist on the covering physicians increasing their limits because neither of them individually could bear your 58 patients, and both of them together are dangerously close to a combined limit, which does not account for any coverage they will need between themselves.

In summary, it is essential to be aware of the prescribing limits, both of your own and of the individuals covering for you. Ensure that there is always staff available to cover all active prescriptions at any given time. Please note, "active" here means that patients are in maintenance phase (not in detoxification).

One DEA Visit – one primary care provider tale

One Tuesday morning, I was contacted by the VA police indicating that a DEA agent was here to see me. I was expecting this visit – as a DATA 2000 waivered physician prescribing buprenorphine I understood that the DEA was visiting all credentialed providers (whether they prescribed buprenorphine or not) over the next several years. I indicated that I was not in clinic at present, and in fact, not on the VA campus where the DEA agent was located (I later learned that the agents go to the location on the provider's license). I spoke with the agent, and we agreed to meet at a mutually agreed location in the VA the following week.

I contacted the VA pharmacy and asked them to provide me a print out with a list of all my buprenorphine and buprenorphine/naloxone prescriptions in the previous 30 days. I had about 72 patients listed. I brought this list to my meeting with the DEA agent.

The visit was cordial. He identified himself and showed me his badge from a wallet. I signed a paper indicating that this was a DEA visit for DATA-2000 enforcement. He asked to "see a list of your suboxone patients". I showed him the print out. He asked to keep it. I countered that I was concerned that there are identifiable patient information on this list, and asked if I could print out another list indicating no patient information (names / social security information). He agreed. He asked to look at a few of my charts. He randomly looked at two charts in CPRS with me. He looked to see that they were being treated for opioid dependence and whether there was documentation of the visit with the patient. He said everything looked good.

He looked at a sheet of paper that he brought with him. He indicated that I was only approved for 30 patients for treatment, and indicated that he was concerned that I was "over the limit". I indicated that this was incorrect, as I had been granted a waiver to treat 100 patients at any one time several years ago. He asked me to send to him (later via email) this waiver [the waiver is a letter from SAMHSA/CSAT indicating that they have received the waiver request and indicates that the provider can treat 100 patients at any one time, luckily I had this letter available – but this was in another office, and unavailable during the visit].

Interestingly, he also added some comments and specifically indicated that he was in communication with the drug company (which he named) that provides buprenorphine. He indicated that "the drug company is recommending that you do not go over 16mg for any patient. We are seeing a lot of diversion of this medication, we suggest that you do not provide more medication than appropriate. You should not be using the mono-product and only the combination product". I agreed. He indicated that my DEA license should be the same address that I am seeing patients. I indicated that I have several offices, and that it may be difficult to do this. He persisted, and indicated that he will change my DEA address to the address that I am providing buprenorphine. He indicated that I have no problems with my license.

He asked whether I dispense buprenorphine in my VA clinic. I indicated no. He indicated that this visit will be "easier" because I am not dispensing buprenorphine. He related that he has had quite a bit of problems with providers who are dispensing the medications – particularly regarding recording the amount of buprenorphine on hand and dispensation records. I indicated that this is unlikely to be a problem in office-based care in the VA, and he agreed.

He asked to talk to pharmacy. He called pharmacy and asked to speak to a pharmacist who could attest that I am approved for buprenorphine and not over my prescriber limit. He called the pharmacy with me in the room. The call was cordial. He asked a few questions including, "Does the pharmacy dispense all of Dr. X's prescriptions of buprenorphine? [yes] Is Dr. X over the limit to prescribe, and can you easily find account for the patients prescribed buprenorphine at any one time? [no and yes]. Thank you, it was great talking to you (the pharmacist) again."

He indicated that he was done, provided me his contact information, and left the building. The total visit time was less than 30 minutes (we did a bunch of chit chat – it really was about 20 minutes of business). I emailed my documentation of my waiver to 100. Three weeks later, he emailed me back indicating that I did not send this waiver to him. I replied again, attaching my previous email, and he responded that "You are fine, it has been busy in the office…"

My overall impression was that the visit was cordial and pleasant. It is obviously nerve racking to be "visited" by a DEA agent, but the agent assured me that this was not a "for cause" visit. I was happy to have prepared by knowing how many patients that I had on buprenorphine and that our pharmacy knew what to expect regarding questions regarding my care of opioid dependent patients. My documentation, luckily, was also good. I got the sense that the agent was going through the motions of the visit – certainly this was not a "sexy visit to get" me at anything. He was not alarmed regarding his documentation regarding my patient waiver limit – and indicated that "he may have old documentation".

Buprenorphine and medication-assisted addiction treatment in the news

Good press *and* bad press.

"BioDelivery Sciences Announces Confirmation of Final Formulation of BEMA Buprenorphine/Naloxone Based on Positive BNX-102 Study". Press Release. Marketwatch. Dec. 20, 2011.
"Suboxone use in Portland: A lifeline for recovering addicts or a new abuse problem?" Seth Koenig. Bangor Daily News. Dec. 27, 2011.
"Relapse in an Era of Buprenorphine". J.T. Junig, MD, PhD. PsychCentral. Dec 2011.

Transition in the BIV

My name is Dan Harding and I am taking over Margaret Krumm's role as the Buprenorphine Initiative in the VA (BIV) coordinator. I have some large shoes to fill as Margaret's curiosity and passion for helping providers and patients fueled a great deal of her interest in medicine. She wasextremely proficient and educated in informing others of the merits of Buprenorphine treatment. I have worked for Adam J. Gordon, MD MPH for three years. My background is in childhood social work expanded to Veteran-focused care. Dr. Gordon's special interests in the field of addiction medicine have led me to positions as Project Coordinator with numerous studies, mainly in the area of alcohol treatment and homelessness. I am excited to include medication-assisted treatment of opiate additions to my experience by serving you as best I can through the BIV. Best wishes to Margaret in her care of patients, wherever that may take her!

Research update

Non-medical use of opioids among HIV-infected opioid dependent individuals on opioid maintenance treatment: the need for a more comprehensive approach.

Roux P, Carrieri PM, Cohen J, Ravaux I, Spire B, Gossop M, Comer SD.
Harm Reduct J. 2011 Nov 28;8(1):31. [Epub ahead of print]

Medication-assisted treatment research with criminal justice populations: challenges of implementation.

Gordon MS, Kinlock TW, Miller PM.
Behav Sci Law. 2011 Nov;29(6):829-45. doi: 10.1002/bsl.1015.

Co-occurring amphetamine use and associated medical and psychiatric comorbidity among opioid-dependent adults: results from the Clinical Trials Network.

Pilowsky DJ, Wu LT, Burchett B, Blazer DG, Woody GE, Ling W.
Subst Abuse Rehabil. 2011 Jan 1;2:133-144.

This information is supported and provided by the Substance Use Disorder Quality Enhancement Research Initiative (SUD-QUERI), Center of Excellence in Substance Abuse Treatment and Education (CESATE), the Mental Illness Research, Education and Clinical Centers (MIRECC), and the Program Evaluation and Resource Center (PERC) within the Department of Veterans Affairs. Please contact Dan Harding at John.HardingJr@va.gov or 412-954-5207 with questions or comments.