



**Bureau of Substance
Addiction Services**

Practice Guidance for Hospital and Opioid Treatment Program (OTP)
Coordination of Care

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Definitions

Long-Term Care Facility (LTCF) - any institution, whether conducted for charity or profit, that is advertised, announced, or maintained for the express or implied purpose of providing four or more individuals admitted thereto with long-term resident, nursing, convalescent or rehabilitative care; supervision and care incident to old age for ambulatory persons; or retirement home care for elderly persons. Long-term care facilities shall include convalescent or nursing homes, rest homes, infirmaries maintained in towns, and charitable homes for the aged.

Massachusetts Prescription Awareness Tool (MassPAT) - an electronic system to monitor the prescribing and dispensing of all schedule II to V, inclusive, controlled

substances and certain additional drugs by all professionals licensed to prescribe or dispense such substances.

Medication for Opioid Use Disorder (MOUD) - medication approved by the FDA for the treatment of an opioid use disorder.

Opioid Treatment Program (OTP) - a federally-certified and state-licensed program, usually comprised of a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using approved medications, of individuals who are addicted to opioids. OTPs may utilize methadone, buprenorphine, and naltrexone. Most commonly, OTPs treat patients with methadone.

Skilled Nursing Facility (SNF) - a facility or units thereof that provide continuous skilled nursing care and meaningful availability of rehabilitation services and other therapeutic services in addition to the minimum, basic care and services required in 105 CMR 150.000 for residents who show potential for improvement or restoration to a stabilized condition or who have a deteriorating condition requiring skilled care.

Take-Home Medication - also known as unobserved dosing, where patients who meet federal and state criteria are permitted to take their medication outside (e.g., a patient's home) the OTP and is based on an individualized assessment by the clinical judgment of the OTP practitioner.

Hospital Coordination of Care with Opioid Treatment Programs (OTPs) for Patients with Opioid Use Disorder

The Massachusetts Department of Public Health, Bureau of Substance Addiction Services (BSAS), recognizes that an inpatient hospitalization or any hospital patient contact provides an opportunity to engage people with opioid use disorder (OUD) in

treatment and overdose prevention. Therefore, BSAS supports hospitals to a) effectively treat and manage acute opioid withdrawal, b) ensure patients who receive medication for opioid use disorder (MOUD) maintenance medication continue their medication without disruption while hospitalized, and c) facilitate the initiation of MOUD and linkage to care in the community upon discharge from the acute hospitalization, for those who are not currently receiving MOUD.

Communication and coordination of care between the hospital and Opioid Treatment Program (OTP) are crucial to ensure the uninterrupted continuation of methadone treatment and care. An efficient and open communication system model can help formalize care coordination networks that leverage the resources and expertise of each system and organization. Federal and state regulations include pathways to ensure continuation or initiation of treatment for opioid use disorder with methadone may occur outside of an OTP with restrictions.

Federal Regulations Support for OTP and Hospital Coordination of Care - Revised Rule

The Substance Abuse and Mental Health Administration (SAMHSA), the federal certifying body for opioid treatment programs, released updated regulations (42 CFR Part 8 *Medications for the Treatment of Opioid Use Disorder*) in January 2024 that went into effect in April 2024. This was the first significant change to OTP treatment and methadone medication regulations in over 20 years. The changes are supported by evidence-based research and draw on lessons learned from necessary policy and guideline changes and regulatory exemptions initiated during the COVID-19 Public Health Emergency. The revised rule supports an expedited admission process, shared practitioner-patient decision making, OTP practitioners' clinical judgment, responsive and flexible OTP services including telehealth, use of evidence-based practices, and the use of non-stigmatizing language. BSAS fully aligned its regulations

for OTPs with the federal regulations by issuing [statewide blanket waivers and guidance](#).

What Is An OTP?

Per federal and state regulations, methadone to treat opioid use disorder (OUD) can only be dispensed through a federally certified and BSAS-licensed Opioid Treatment Program (OTP). OTPs are federally certified, registered, and accredited entities that provide comprehensive services for people with OUD and other related substance use disorders (SUDs), and related physical and mental health conditions, through a multidisciplinary team of dedicated healthcare professionals. OTPs dispense and administer methadone, and increasingly also offer buprenorphine and naltrexone, the three FDA-approved medications to treat opioid use disorder.

OTPs play a critical role in OUD treatment by offering lifesaving medications that can lower the risk of opioid-related overdoses and overdose-related deaths, treat opioid withdrawal, and stabilize individuals with OUD. They offer medical care and non-pharmacological behavioral health services, including counseling and other interventions, peer support, care management, and referrals to community recovery organizations where patients can access additional recovery supports.¹

Pathways for Initiating or Continuing Methadone Treatment for Opioid Use Disorder (OUD) Outside of an OTP

Based on Federal regulations, certification as an OTP is not required for the initiation, continuous medication treatment, or withdrawal management of a patient admitted to a hospital, long-term care facility, or correction facility that is registered with the

¹ [Federal Guidelines for Opioid Treatment Programs – Winter 2025](#)

DEA as a hospital/clinic for the treatment of medical conditions other than OUD, as long as such treatment is permitted under applicable Federal law.² In other words, inpatient hospitals treating patients for a medical reason other than OUD may simultaneously continue existing methadone treatment for OUD, or initiate methadone for the purpose of treating opioid withdrawal. As mentioned above, communication between the hospital and the patient's OTP, or prospective OTP if the person is initiated on MOUD in the hospital, is crucial.

BSAS encourages hospitals to adopt policies that ensure staff are trained in substance use disorders and the various assessments and treatment options, including the three FDA-approved MOUD (methadone, buprenorphine, and naltrexone). For more information on this topic, see SAMHSA's Treatment Improvement Protocol (TIP) 63: *Medications for Opioid Use Disorder*³ and [Providers Clinical Support System- Medications for Opioid Use Disorders \(PCSS-MOUD\)](#). Hospital staff should be trained to assess whether patients presenting with opioid use disorder are already receiving MOUD.

Bridge Programs and The Drug Enforcement Administration's "3-Day Rule"

Hospitals and emergency departments should establish policies for direct admissions/referrals to OTPs. Hospitals are often the first point of care for patients who may be experiencing an overdose. In accordance with [21 CFR 1306.07\(b\)](#), non-OTP practitioners may dispense methadone in accordance with applicable Federal, state, and local laws relating to controlled substances to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment, or both. No more than a three-day supply may be dispensed to the person at one time while arrangements are being made for referral to an OTP.

² [42 CFR 8.11 Opioid Treatment Program Certification](#)

³ [SAMHSA'S TIP 63: Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families](#)

This is widely referred to as the “3-Day Rule.” Additionally, peer support specialists can be used to provide a warm handoff from the emergency department to the OTP, ensuring that the patient accesses OTP services after being released from the emergency department.

Partnerships between hospital emergency departments and OTPs, in addition to other medical providers serving patients with OUD, are known as *bridge programs*. Through bridge programs, hospitals can build and maintain a direct admission relationship between the hospital program and an OTP. This typically follows individual-level professional relationships between the medical program and OTP staff, initially established around discussing the needs of individual patients.

In accordance with 21 CFR 1306.07(b), practitioners in dedicated *bridge programs* may dispense methadone under the “3-Day Rule”, also known as the “72 Hour Rule”. Through this pathway, the bridge program becomes a rare setting where patients may be offered the full range of MOUD options, along with a comprehensive medical evaluation and assistance with challenges such as transportation that could interfere with OTP attendance. ⁴

Coordination of Care for OTP Maintenance Patients Admitted to a Hospital

OTPs are required to document when a patient has been admitted to a hospital and thus are not able to take methadone or buprenorphine dispensed through the OTP. Once the OTP learns that the patient is admitted to a hospital (which is usually when the hospital calls the OTP to confirm the patient’s last dose), the OTP will place the patient on a “suspended” status until they receive confirmation from the hospital that the patient is being discharged back to the OTP to continue their maintenance

⁴ [Federal Guidelines for Opioid Treatment Programs - Winter 2025](#)

treatment. This is a crucial step in order to avoid the patient receiving methadone from multiple sources.

Hospital staff should ask the OTP if the patient has take-home medication, including when they received the last medication and how many doses. Best practice dictates that if the hospital staff changes the methadone dose, that information is directly conveyed to the OTP medical team for coordination of care upon discharge. When the patient is discharged from the hospital, the hospital care team should communicate with the OTP about how the MOUD was managed, including any dosing changes, via a “last dose letter” which should be included in the discharge documents sent to the OTP.

Medications for opioid use disorder are not currently entered into the MassPAT prescription monitoring program. Direct communication between the OTP and the Hospital should occur to ensure coordination of care.

BSAS 24-Hour Community-Based OTP Dose Verification Process

Once it is confirmed that a patient is enrolled in an OTP and is receiving maintenance treatment, patients should be able to continue to receive their medication while inpatient for the treatment of medical conditions other than OUD. This should be done by directly coordinating care with community-based OTPs to verify the last medication dose.

OTPs are required by regulation to have a system in place to address patient medical or psychiatric emergencies and dose verification occurring outside of program hours of operation, and must be available 24 hours a day, 7 days a week. The BSAS [24-Hour Community-Based OTP Dose Verification Resource List](#) includes the names of agencies, their locations, and dose verification contact numbers throughout the state, which any provider may use. If a provider needs to verify a patient’s dose, they should

refer to this resource. If no response is received from the OTP within one hour, staff should contact the [Massachusetts Substance Use Helpline](#) or call 1-800-327-5050 to ensure they have the current numbers for the OTP. Note that OTPs are outpatient service settings and, therefore, may have separate 24-hour dose verification phone numbers that differ from their main numbers.

Coordination of Care for Patients Inducted on Methadone at the Hospital

It is crucial for the hospital to ensure a direct admission to a community-based OTP upon discharge from the hospital for the patient to be admitted to the OTP for maintenance treatment. The hospital care team should identify an appropriate [community OTP](#) based on the patient's preference, residential location, and consideration of transportation issues. The hospital should ensure the OTP receives the patient's medical record as it pertains to the opioid use disorder treatment in the hospital (including the examination and other documentation noted above to the identified OTP), reach an agreement with the OTP on an admission date, and communicate with the accepting OTP about the dosage, the date of the last dose given at the hospital, and how many take-home bottles were given to the patient at discharge. This is done via the "last dose letter," which should be included in the discharge packet sent to the OTP, with a copy provided to the patient and instructions to present it to the OTP upon admission.

Direct communication and coordination of care is required for patients inducted/initiated on methadone for opioid use disorder at the hospital and transferred to a skilled nursing/rehabilitation facility (SNF) or a long-term care facility (LTCF). These patients will require admission to a community-based OTP that will collaborate directly with the receiving facility to ensure ongoing maintenance of methadone. This coordination between the hospital, SNF/LTCF, and the OTP

provider is essential to avoid interruption in MOUD upon discharge from the hospital setting.

Hospitals and OTPs should communicate in order to know how much medication was given to the patient by each facility, including by the OTP upon admission to the hospital and by the hospital upon discharge.

Why isn't Methadone for Treating OUD in the MassPAT?

Due to current legal privacy restrictions, medication dispensed at an OTP is not included in the Massachusetts Prescription Awareness Tool (MassPAT) prescription monitoring program. Therefore, to confirm the date and dose of the last OTP medication received by a patient, hospitals should directly communicate with the patient's OTP provider if the patient is receiving any form of MOUD at a community OTP. Direct communication ensures coordination of care for both the OTP and the hospital. Communicating directly with the OTP provides the hospital care team with information about the patient's OTP treatment, facilitates care coordination, and prevents the concurrent administration of MOUD from multiple sources. Generally, buprenorphine for opioid use disorder treatment prescribed outside of an OTP will be found in the MassPAT. Methadone for pain treatment and management will be found in the MassPAT.

Methadone/Buprenorphine OTP Take-Home Doses Unobserved Dosing

Generally, per federal and state OTP regulations, OTP patients must present at their OTP for observed dosing directly dispensed by the OTP nurse. Updated Federal and state regulations now allow patients to receive higher numbers of take-homes earlier in treatment and to increase the number of take-homes earlier in treatment than

previous regulations allowed. An OTP patient presenting at a hospital may have received take-home methadone dispensed to the patient in individual pre-poured bottles. Additionally, practitioners at hospitals, under the 3-Day Rule, may dispense methadone to a patient upon discharge.

The table below shows the number of take-homes or unobserved doses an OTP patient may receive per regulation, based on the number of days a patient is enrolled in treatment.⁵ The OTP practitioner determines the number of take-homes a patient may receive based on other clinical factors. All unobserved dosing decisions are the responsibility of the OTP practitioner under the oversight of the medical director.



Use of Non-OTP Practitioner Assessments - Expediting Direct Referrals to OTPs

An important aspect of the revised rule is the ability and option to use a non-OTP practitioner's examination to expedite the OTP admission process. If the licensed practitioner is not an OTP practitioner, the screening examination must be completed no more than seven days prior to OTP admission. Where the examination is performed outside of the OTP, the written results and narrative of the examination, as well as available lab testing results, must be transmitted, consistent with applicable privacy laws, to the OTP, and verified by an OTP practitioner.⁶

⁵ [DPH BSAS Waiver from Certain Regulatory Requirements and Guidance – 42 CFR Part 8 and 105 CMR 164.000-OTP Revision](#)

⁶ [42 CFR 8.12 Federal Opioid Use Disorder Treatment Regulations](#)

A full physical examination, including the results of serology and other tests that are considered to be clinically appropriate, must be completed within 14 calendar days following a patient's admission to the OTP. The full exam can be completed by a non-OTP practitioner if the examination is verified by a licensed OTP practitioner as being true and accurate and transmitted in accordance with applicable privacy laws.⁷⁸

It is the responsibility of the OTP practitioner to ensure that any examination occurring outside the OTP meets the regulatory requirements for admission to an OTP. With proper consent obtained by the hospital, a [non-OTP practitioner's findings](#) can be transmitted to the OTP, where an OTP practitioner reviews, verifies, and integrates the findings into the patient's care plan. For example, the screening examination and/or full history and examination could be completed by a primary care provider, an emergency department practitioner, or a hospital addiction medicine consultant. The report can then be faxed, securely emailed, or transmitted through a health information exchange that is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part 2 for review and verification by the OTP practitioner.

Although this flexibility makes accessing OTP services faster and easier for everyone, it is particularly important for people who are being released from a hospital or correctional facility, where they may have already been receiving MOUD. As more hospitals and correctional settings offer MOUD, there is a greater need to ensure medication continuity for patients moving into the OTP setting. The revised rule enables OTPs to work with practitioners at local hospitals and correctional facilities, lowering barriers to ongoing care.

⁷ [42 CFR 8.12 Federal Opioid Use Disorder Treatment Regulations](#)

⁸ [DPH BSAS Revised Waiver from Certain Regulatory Requirements](#)

Resources

- Regulations
 - I. Federal 42 CFR Part 8 Final Rule
<https://www.samhsa.gov/substance-use/treatment/opioid-treatment-program/42-cfr-part-8>
 - II. DPH BSAS Regulations 105 CMR 164.300
[https://www.mass.gov/info-details/information-for-licensed-substance-use-disorder-treatment-programsBSAS Information for Substance Use Disorder Treatment Programs](https://www.mass.gov/info-details/information-for-licensed-substance-use-disorder-treatment-programsBSAS%20Information%20for%20Substance%20Use%20Disorder%20Treatment%20Programs)
 - III. DPH BSAS Regulatory Waiver / Guidance
[DPH BSAS Revised Waiver from Certain Regulatory Requirements and Guidance 42 CFR Part 8 and 105 CMR 164.000](#)
- [SAMHSA Advisory June 2025 - Expanding Access to Methadone Treatment in Hospital Settings](#)
- [SAMHSA TIP 63: Medications for Opioid Use Disorder](#)
- [The Care of Residents with Opioid & Stimulant Use Disorders in Long-Term Care Settings Toolkit](#)
- [SAMHSA Advisory June 2025 - Expanding Access to Methadone Treatment in Hospital Settings](#)
- [Updated Admission of Residents on Medication for Opioid Use Disorder \(MOUD\) to Long-Term Care Facilities](#)