RESOURCES ON THE REQUIREMENTS OF AB474

- AB474 Webinar Recording for 12/18/17: http://www.nsbom.org/LicensingPublic/docs/WEBINARAB474(121817).mp4
- Link to AB474 law on BOM website at: www.bom.nv.gov
- Submit Questions about AB474 to: AB474FAQS@HEALTH.NV.GOV
- Nevada State Medical Association: www.nvdoctors.org
- Nevada Division of Public and Behavioral Health web page, general info, and info on AB474 and Requirement for Reporting an Overdose: http://dpbh.nv.gov/Resources/opioids/Prescription_Drug_Abuse_Prevention/

OVERVIEW OF NEW REGULATIONS UNDER AB 474 - LCB FILE NO. R116-17

- Osteopathic Physicians: Ten hours of category A-1 courses
- Osteopathic Physicians: Two hours that relate to the misuse and abuse of controlled substances, the prescribing of opioids or addiction.
- Osteopathic Physicians: On or after July 1, 2018, each osteopathic physician shall, not later than 2 years after initial licensure and at least once every 4 years thereafter, attest to the Board when applying for renewal of his or her license that he/she has received the instruction on evidence-based suicide prevention and awareness.
- Physician Assistants: Included in the completion of 20 hours of annual continuing medical education completion of at least 2 hours which must relate to the misuse and abuse of controlled substances, the prescribing of opioids or addiction.

BOARD/STAFF NEWS...

Board: Ronald Hedger, D.O., was reelected in January to serve as Board President; Paul Mausling, D.O., was elected Board Vice-President. We thank Ricardo Almaguer, D.O., for his service as the previous Board Vice President. Ricardo Almaguer, D.O., has been reappointed to serve on the Board for an additional four years, beginning July 1, 2018. Dr. Almaguer has served on the Board since July 2010.

Staff: In October 2017, the Board welcomed James Atchazo as the new staff investigator, replacing the previous investigator position. Jim has worked as an investigator for the Nevada Equal Rights Commission and the Department of State - Bureau of Diplomatic Security.

Mission: The Nevada State Board of Osteopathic Medicine's mission is to protect and safeguard the public by licensing and disciplining well-educated and competent Doctors of Osteopathy and Physician Assistants.
CURRENT MEMBER LIST- INTERSTATE MEDICAL LICENSURE COMPACT (IMLC)

- NEVADA
- ALABAMA
- ARIZONA
- COLORADO
- DISTRICT OF COLUMBIA
- GUAM
- IDAHO
- ILLINOIS
- IOWA
- KANSAS
- MAINE
- MARYLAND
- MINNESOTA
- MISSISSIPPI
- MONTANA
- NEBRASKA
- NEW HAMPSHIRE
- SOUTH DAKOTA
- UTAH
- VERMONT
- WASHINGTON
- WEST VIRGINIA
- WISCONSIN
- WYOMING

For more info on our web site go to: http://nsbom.org/LicensingPublic/licensurecompact.jsp;

To apply for an interstate medical license (DOs only), go to: http://www.imlcc.org/

Closing your practice?
The statute requires practitioners to notify the Board in writing 30 days before closing your practice. See NRS 633.291; NAC 633.260(1)(2) for full details.

Notify patients:
Per NRS 633.511(1)(n), it is best practices to give similar adequate notice to patients when closing or changing your practice.

Also Note: Malpractice settlements involving minors (under 18 years old), must be approved by the courts. However, the NPDB may receive settlement notification by an insurance carrier prior to court approval, starting the reporting timeline in our statute. Be sure to communicate with your insurance company to comply with the reporting timeline.

2018 BOARD MEETINGS

January 9
February 13
March 13
April 10
May 8
June 12
August 14
September 11
October 8
November 13
December 11

ALL MEETINGS ARE HELD AT THE BOARD OFFICE AT 5:30 p.m. UNLESS OTHERWISE STATED

Licensing Applications

January-June 2018
DO - 117
PA - 36
Residents - 114
Total licensees - 1792

Calendar Year 2017
DO - 158
PA - 39
Residents – 95
Total licensees - 1611

Enforcement Stats January-June 2018

Complaints Reviewed/Investigated
65
Settlement/Remediation Agreements with Licensees
02
Complaints resulting in a Letter of Caution
05
Complaints resulting in a Letter of Admonishment
01
Complaints Authorized for Closure
57
Fulfilled Agreements
02

Enforcement Stats Total- 2017

Complaints Reviewed/Investigated
119
Settlement/Remediation Agreements with Licensees
02
Complaints resulting in a Letter of Caution
19
Complaints Authorized for Closure
76
Fulfilled Agreements
04

Types of Complaints*- 2018 Jan-June

Medical Malpractice – 7
Medical Records/Billing – 19
Patient Discharge – 5
Prescribing – 20
Standard of Care – 29
Unprofessional Conduct – 21
*Some types overlap

Board License/Renewal Fees

INITIAL LICENSE FEE: DO-$650*; PA-$450*; FEE INCLUDES FINGERPRINT CARDS
MILITARY DISCOUNT: 50%– DO-$300; PA-$200
RENEWAL FEE: DO-$450; PA-$250
ACTIVE MILITARY RENEWAL FEE: $0 (NO COST)
*Fee Change: Fingerprint/background fees have been reduced to $50.

Reporting Disciplinary/Malpractice Actions

Please Note: As per NRS 633.527, all licensees are required to report all actions in which they are named, including disciplinary, malpractice claims, fulfillment and removal, within 45 days of the action. The National Practitioner Data Bank (NPDB) reports to the Board all disciplinary, malpractice and positive settlement fulfillments and disciplinary action removals.

Also Note: Malpractice settlements involving minors (under 18 years old), must be approved by the courts. However, the NPDB may receive settlement notification by an insurance carrier prior to court approval, starting the reporting timeline in our statute. Be sure to communicate with your insurance company to comply with the reporting timeline.

Reaching Out…The Board hosted two webinars in November and December 2017, for licensees and other interested Boards and parties, about the requirements of AB474—the new controlled substance prescribing law, enacted on January 1, 2018. Board Executive Director, Sandy Reed, presented before the Governor’s Opioid State Action Accountability Task Force in September 2017 and April 2018, outlining the measures the Board has taken to reach out to licensees regarding the adherence to AB474. Ms. Reed conducted a similar presentation before the Legislative Commission’s Sunset Subcommittee on Health Care in March 2018.
Every Nevadan, whether physician, patient, or citizen, has been impacted by the prevalence of opioids in our community. In response to the nationwide opioid epidemic and the effects felt in Nevada, Governor Sandoval brought forth legislation known as the Prescription Drug Abuse Prevention Act (AB474). Passed unanimously by the legislature, AB474 goes into effect on January 1, 2018 and will impact all prescriptions for controlled substances, although most provisions of the law uniquely apply to controlled substances prescribed to treat pain.

As an advocate for physicians, the Nevada State Medical Association (NSMA) understands that there is much angst about how to comply with the new law. It is critical that physicians (including residents) and physician assistants take the time to understand these requirements so that you can best treat your patients within the confines of the law. The key to successfully complying with AB474 is to clearly understand what is required, focus on what you can do now to prepare, and to consider some best practices to assist your workflow.

**Requirements of AB474**

The law’s requirements are best understood broken down into five categories, with the most significant changes being the new provider guidelines found in sections 52-58 of AB474. The five categories are: (1) required reports of overdoses; (2) continuing medical education (CME) requirements; (3) mandated registry and use of the prescription monitoring program (PMP); (4) required prescription components; and (5) prescriber guidelines.

I. **Providers Will Be Required to Report Cases of Overdose.**

Under AB474, a physician, physician assistant, nurse or veterinarian licensed in accordance with Nevada state law will be required to report actual or suspected cases of drug overdoses to the State’s Chief Medical Officer (State of Nevada Division of Public and Behavioral Health - DPBH). DPBH approved regulations in May 2018 which provide that: (1) hospital-based overdoses will be reported by hospitals to the state, (2) physicians who treat out-patient and believe a patient’s overdose has not been reported should report, and (3) forms are available at www.prescribe365.nv.gov. Note that this requirement applies to all schedules of drugs I-V. Hospice and palliative care are exempt from this requirement.

What should you do now? Hospital-based physicians should ensure that the hospital has protocols in place that allow physicians to efficiently report overdose date to the appropriate hospital personnel. Non-hospital-based physicians should establish a work flow which includes the state form for reporting patients presenting upon an overdose that has not resulted in a hospital visit.

II. **Providers Are Required to Obtain Two Units of Continuing Medical Education on the Topic of Misuse and Abuse of Controlled Substances, the Prescribing of Opioids or Addiction.**

Under the new law, all licensed providers registered to dispense controlled substances will be required to complete two (2) units of CME each licensing cycle specifically to the misuse and abuse of controlled substances, the prescribing of opioids or addiction. The units may be substituted for ethics or any other general requirement. Entities like NSMA and our county medical societies, Project ECHO and others frequently offer these CME opportunities, and many exist online.

What should you do now? Look for opportunities to fulfill these two units of CME. The first two units must be completed by the 2019 licensing cycle.

III. **Providers with Licenses to Prescribe Must Register for and Query the PMP.**

The Prescription Drug Monitoring Program (PMP) is a computerized program that tracks prescriptions for controlled substances. It is housed by the Nevada State Board of Pharmacy (BOP) and is accessible at all hours through a secure website. According to data provided by the BOP, 83.5% of MD and 87.8% of DO
prescribers are registered with the PMP, but only 10.7% of DOs and 15% of MDs queried the system in 2016. While we expect those numbers to be higher in 2017, the law now requires both registry and use.

All prescribers of any controlled substance must check the patient’s utilization report in the PMP before issuing an initial prescription and at least once every 90 days for the duration of that course of treatment. The PMP is a tool to help the provider assess the medical necessity of prescribing the controlled substance for that patient. Providers may use extenders or agents to access the PMP but must review the information themselves. If the provider determines that the PMP does not support medical necessity or if the patient has already been issued a prescription for the same controlled substance to treat the same diagnosis for the same period of time, the provider must not issue an additional prescription.

What should you do now? Register for the PMP at: https://nevada.pmmpaware.net or call the Nevada Prescription Monitoring Program at 1-855-5NV-4PMP and begin checking the PMP before issuing an initial prescription and every 90 days for all controlled substances, including opioids for pain.

IV. To Be Valid, Prescriptions Must Contain the Patient’s Date of Birth, ICD-10 Code, the Fewest Number of Days Necessary to Consume the Medication, and the Prescriber’s Name and DEA License Number.

In addition to current requirements, all prescriptions must now contain four elements along with the medication being prescribed: (1) patient’s date of birth; (2) patient’s diagnosis through the ICD-10 code, (3) the lowest number of days the medication is intended for; and (4) the prescriber’s name and DEA number. Through regulations promulgated by the BOP, pharmacists working with prescriber offices can work to correct a lack of an ICD-10 code or a number of days dosage but cannot assign a DEA number to a prescription, even if the pharmacist personally knows the prescriber. If multiple practitioners’ names and DEA numbers are printed on the prescription form, the prescription cannot be filled unless the prescribing practitioner and DEA number are clearly indicated.

It is important to note that for electronic prescriptions, electronic medical record/electronic health record (EMR/EHR) systems doing business in Nevada must offer the ability to transmit a legal prescription. If your practice is having any issues getting your EHR/EMR systems in place, the BOP or the NSMA can help intervene.

What should you do now? Ensure preprinted prescriptions and EMR/EHR system contain new requirement for legal prescriptions, including the ability to clearly delineate the DEA number of the prescriber.

V. All Prescribers of Controlled Substances Must Follow New Prescribing Guidelines.

The most substantive provisions of AB474 are the provider guidelines. Nevada policy-makers approached this legislation with the stated objective to prioritize patient safety and responsibility and to preserve clinical judgment in the face of addressing a public health crisis. There are some requirements that apply to all prescriptions for controlled substances; however, most provisions apply only to those controlled substances prescribed to treat pain.

a. Prescriptions for All Controlled Substances Require the Prescriber to Query the PMP, Consider Important Factors Prior To Prescribing and Write the Prescription in Accordance with the New Law.

For all prescriptions of controlled substances, the prescriber must query the PMP upon initial prescription and at least once every 90 days during the course of treatment. Here, the provider is using the PMP as a tool to consider medical necessity and must refrain from prescribing if the prescription is not medically necessary or if another prescription exists to cover that diagnosis and time.

Providers must also consider certain factors, if applicable, prior to prescribing. These factors are itemized in the law, and include considerations such as any history of aberrant behavior or public intoxication, unauthorized increase in dosage of controlled substance, or substance abuse, any evidence that the patient has been addicted to, misused, abused or diverted a controlled substance, reluctance to discontinue usage despite improvement, lack of cooperation, or discharge from other provider clinics, any changes in the patient’s health (such as pregnancy), or any other factors that may that may influence or affect the decision to prescribe.
In addition, the prescription for any controlled substance must contain the statutory requirements as explained above: current requirements plus patient’s date of birth, ICD-10 diagnosis, minimum number of days for the prescription and the prescriber’s name and DEA license number.

a. Prescriptions for Controlled Substances to Treat Pain Have Additional Requirements.

Prescriptions for controlled substances issued to treat pain include the above requirements and more. Although the hard caps prevalent in other states are not found in the new Nevada law, the general guidelines on prescribing controlled substances for pain include three specific “restrictions” to achieve policy objectives.

First, a patient may not receive more than 365-days’ worth of controlled substances to treat pain during a 365-day period, or 90-days’ worth of medication in a 90-day period.\(^\text{12}\) This is intended to reduce overprescribing and duplicative prescribing.

Second, initial prescriptions for a controlled substance to treat acute pain may be no more than 14 days – and allow for one refill.\(^\text{13}\) This was a negotiated provision, intended to strike a balance between reducing the amount of prescribed controlled substances initially issued for an acute injury without requiring the patient to seek a refill or be required to follow up after only 7 days. It may be appropriate to prescribe less than 14 days for an acute injury. Emergency departments routinely prescribe less than 7 days and national pharmacy chains such as CVS have implemented a 7-day maximum on prescriptions for acute pain.\(^\text{14}\) The Nevada law, however, allows you to prescribe an initial prescription of 14 days if your clinical judgment determines this is appropriate.

Third, prescriptions for opiates written to an opioid naïve patient (a patient who has not had an opiate for 19 days) may not be more than 90 morphine milligram equivalents (MME).\(^\text{15}\) This is intended to encourage prescribing of the lowest effective dosage and tracks guidance by the CDC guidelines that encourages “go low and go slow.”\(^\text{16}\) Note that if you inherit a patient that has been issued an opiate, you are not subject to this restriction; however, you should use your clinical judgment to prescribe within the standard of care.

b. Requirements for Prescriptions for Controlled Substances to Treat Pain Increase as You Prescribe for Under 30 Days, 30 Days, and 90 Days.

Before issuing an initial prescription, a practitioner must have a bona fide relationship with the patient. The practitioner must perform an evaluation and risk assessment of the patient that includes obtaining and reviewing the medical history, checking the PMP, conducting a physical examination, making a good faith effort to obtain medical records and documenting this effort and any conclusions, assessing the patient’s mental health and risk of abuse, dependency and addiction of the patient using a method supported by peer-reviewed scientific research and validated by a nationally recognized organization. Lastly, the practitioner must obtain an informed consent in writing from the patient prior to prescribing. The statute requires certain components be included in the written informed consent.\(^\text{17}\)

If the course of treatment goes beyond 30 days, you must complete a prescription medication agreement with the patient.\(^\text{18}\) The agreement needs to be updated once per year. Like the informed consent, the statute mandates that this agreement contain certain provisions.\(^\text{19}\) For example, it must include, among many other requirements, the treatment goals, the requirement to take the controlled substance as prescribed, and it must include consent to drug testing as deemed necessary by the provider.\(^\text{20}\) Notably, while the patient must consent to undergo drug testing if required by the clinician, these drug tests themselves are not mandated. Instead it is left up to the provider, in his or her clinical judgment, to require drug testing as deemed medically necessary.

If the course of treatment goes beyond 90 days, the provider must obtain an evidence-based diagnostic work-up. For example, any previous diagnosis of “chronic pain” or “lower back pain” should be replaced by a diagnosis of the cause of the pain. The Provider must discuss the treatment plan with patient and assess the patient for risk of adverse effects from long-term use of controlled substances. The Provider must check the PMP (once every 90 days for the course of the treatment) and review a patient’s completed Risk of Abuse Assessment. For example, a provider can utilize “Screener and Opioid Assessment for Patients with Pain” known as (SOAPP-R) or the Opioid Risk Tool (ORT). These tools are brief self-report screening tools that will assist the provider in determining the medical necessity and risks associated with continued prescribing of controlled substances. If the patient is receiving a prescription in an amount
great than 90 MME, the provider should consider referral to a pain management specialist.

If treatment lasts beyond 90 days, remember that the law requires that you provide no more than 365-days’ worth of controlled substance medication for pain during a 365-day period. Providers should continue to treat patients in accordance with their clinical judgment and the standard of care. If, in the interests of patient care, the provider must deviate from the 365-day requirement, the reasoning must be clearly documented in the patient’s medical record.21

What should you do now? Consider Some Best Practices for Successful Compliance with AB474:

• Contact your patients and let them know that there has been a change in the law that will affect the way you prescribe controlled substances for pain.
• Work with your office managers and other colleagues to plan out your workflow.
• Consider making templates for your EMR/EHR to check off required elements, particularly those that need to be documented:
  o At initial prescription: risk factors considered prior to prescribing, PMP check, attempts to obtain prior medical records and conclusions, consideration of alternatives to opioid therapy and reasons why not selected, obtained informed consent
  o At 30 days: create prescription medication agreement
  o At 90 days: Risk of Abuse Assessment, Evidence-Based Diagnosis and Revised Treatment Plan, PMP check, and consider referral
  o At 365 days: update prescription medication agreement
• Note that recent regulations have clarified that members of the same group may share the same informed consent and pain medication agreement, and that only one informed consent form need be acquired prior to initiating a course of treatment.
• Obtain important sample forms and risk assessment tools. NSMA, the Department of Public and Behavioral Health and Safety and the state licensing boards will have many resources available and accessible online. Links to these websites and other resources can be found online at www.nvdoctors.org.
• State issued prescriber and patient resources can be accessed at Prescribe365.nv.gov.
• Ask for help! NSMA advocates for Nevada’s physicians. NSMA is sponsoring many educational forums on AB474 around the state and is actively working with practice groups and practice group managers to assist in implementation. NSMA members are welcome to contact us at (775) 825-6788 to review workflow issues or set up a CME.

1 The United States is 5% of the world’s population and consumes 80% of the world’s supply of opioids, 75% of the world’s supply of oxycodone, and 99% of the world’s supply of hydrocodone.


3 AB474 text can be accessed at https://www.leg.state.nv.us/Session/79th2017/Bills/AB/AB474_EN.pdf

4 CME requirement found in AB474 Section 16; See also Nevada State Board of Medical Examiners LCB File No. R163-16

5 Register for the PMP at http://nevada.pmpwvao.net or call

6 The “initial prescription” means a prescription originated for a new patient of a practitioner, other than a veterinarian, or a new prescription to begin a new course of treatment for an existing patient of a practitioner, other than a veterinarian. The term does not include any act concerning an ongoing prescription that is issued by a practitioner to continue a course of treatment for a new or existing patient of the practitioner.

7 AB474, Section 60

8 AB474, Section 61

9 The Nevada State Board of Pharmacy has adopted new regulations amending NAC 453.440 to reflect these changes in the law. See LCB File No. R046-17.

10 NAC 638.7120(3)[a] permits a practitioner to issue a prescription using a computer system approved by the Board. After January 1, 2018, any such system will need to comply with the new requirements to be approved.

11 AB474 Sections 52-58. These provisions do not apply to veterinarians.

12 An exhaustive list of factors is found in AB474 Section 57. Whether there is reason to believe that the patient is not using the controlled substance (CS) as prescribed, or is diverting the CS for use by another person; where the patient was previously prescribed the CS, whether it had the expected effect on the patient’s symptoms for which it was prescribed; whether there is reason to believe that the patient is using other drugs, including, without limitation, alcohol or another CS that: may interact negatively with the CS prescribed by the practitioner; or was not prescribed by a practitioner who is treating the patient; the number of attempts by the patient to obtain an early refill of the prescription; the number of times the patient has claimed that the CS has been lost or stolen; irregular or inconsistent information in the patient’s PMP Report that may indicate the patient is using the CS inappropriately; whether previous blood or urine tests indicate inappropriate use of the CS; the need to verify that unauthorized CS are not present in the patient’s body; whether the patient has demonstrated aberrant behavior or intoxication; whether the patient has increased his or her dose of the CS without the practitioner’s authorization; whether the patient has been reluctant to stop using the CS or has requested or demanded a CS that is likely to be abused or cause dependence or addiction; whether the patient has been reluctant to cooperate with any examination, analysis or test recommended by the practitioner; whether the patient has a history of substance abuse; any major change in the patient’s health that would affect the medical appropriateness of the CS; other evidence that the patient is misusing or is addicted to any drug, or is failing to comply with the practitioner’s instructions; any other factor that will help the practitioner make an informed decision as to the medical necessity and appropriateness of the CS.

13 AB474, Section 52(2)

14 AB474, Section 52(2)(a) and 53(2)


16 AB474, Section 52(a)


18 AB474, Section 54(2). The informed written consent must include information concerning: (a) The potential risks and benefits of treatment using the controlled substance, including if a form of the controlled substance that is designed to deter abuse is available, the risks and benefits of using that form; (b) Proper use of the controlled substance; (c) Any alternative means of treating the symptoms and the cause of such symptoms; (d) The important provisions of the treatment plan established for the patient in a clear and simple manner; (e) The risks of dependency, addiction and overdose during treatment using the controlled substance; (f) Methods to safely store and legally dispose of the controlled substance; (g) The manner in which the practitioner will address requests for refills of the prescription, including, without limitation, an explanation of the provisions of section 35 of this act, if applicable; (h) If the patient is a woman between 15 and 45 years of age, the risk to a fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome; (i) If the controlled substance is an opioid, the availability of an opioid antagonist without a prescription; and (j) If the patient is an unanticipated minor, the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

19 AB474, Section 56

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As of January 2016, physicians are required to sign Death Certificates electronically.

http://dpbh.nv.gov/Programs/BirthDeath/hta/Publications/Vital_Records_Publications/

DO YOU HAVE NEWSLETTER TOPIC SUGGESTIONS?
Please email Sandy Reed at: sreed@bom.nv.gov