Controlled Substances (CS) New Mandates, including use of CS in Treating Pain

AB 474 – effective Jan. 1, 2018

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DISCLOSURES

NO CONFLICTS TO DISCLOSE

Joe Hardy, MD, is a Nevada State Senator (District 12)

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Review Journal Article, Saturday, Jan 13, 2018

Board postpones opioid regulations

Implementation delayed after complaints from doctors, lawyers at hearing

By Kimber Laux
Las Vegas Review-Journal

The Nevada Medical Board of Examiners is delaying implementation of a new opioid prescription law after dozens of doctors complained that the change is burdensome and enforcement is confusing.

Assembly Bill 474, which went into effect Jan. 1, requires Nevada licensing boards to create regulations that outline disciplinary actions to be taken against doctors who prescribe opioids in violation of the bill, which requires physicians to perform a risk assessment on patients before writing opioid prescriptions, limit initial prescriptions of the drugs to two weeks and get the patient's consent to random drug testing if the prescription is extended to a month.

Doctors have complained that the risk assessment takes too long and that patients are deterred from seeking help by the threat of random drug testing.

The Board of Medical Examiner's decision Thursday to postpone implementing new regulations resulted from the

See **OPIOID** 4B

The board said it will create an "AB474 Working Group" to study the law, explore how it affects patients and medical providers and collaborate to develop "workable solutions" to the law's requirements.

► **OPIOID**
Continued from Page 1B

complaints of about 40 physicians, lawyers and others who argued during a Jan. 3 meeting that the draft disciplinary rules make unreasonable paperwork demands and do not specify what types of conduct could lead to penalties or revocation of medical licenses.

"We agreed based on comments at the workshop that we should pull back our efforts to implement the draft regulations" and focus instead on developing regulations that would be fair and amenable to licensees, board Executive Director Ed Cousineau said Friday.

The board said in a statement it will create an "AB474 Working Group" to study the law, explore how it affects patients and medical providers and collaborate to develop "workable solutions" to the law's requirements.

Cousineau said the board has not decided who will be in the working group and has no timeline for when the group will meet or when regulations will be submitted for review, but that it likely will be a six-month process. The board's main priority, he said, is getting the appropriate parties involved in drafting the new regulations.

"There's always someone who's not going to get what they want," Cousineau said.

The board has been drafting and revising the regulations contested at the Jan. 3 workshop since AB474 went into effect for administrative purposes in June.

"It wasn't like we were sitting on it," Cousineau said.

The board submitted the draft language at its quarterly meeting in September, received revisions from the Legislative Council Bureau in November and, because it had to wait 30 days to hold a public meeting, opted to conduct the workshop after the holidays, Cousineau said. Once assembled by the board, the working group must propose new regulations to the board for its blessing and wait for the legislative committee's approval to put them into law.

Gov. Brian Sandoval mentioned the bill's turbulent enrollment during a National Governors Association panel discussion Friday.

"I sponsored legislation in the past two Legislatures to combat the opioid epidemic in Nevada. We lose a Nevadan every day because of this," Sandoval said during the panel.

Sandoval said he understands physicians' frustration with the law, but ultimately, doctors share the same goals as the legislators who wrote and passed AB 474: to curb the over-prescribing of opioids in Nevada.

"I still think that the legislation is incredibly important in terms of saving lives, and we'll continue to work with the medical community to get them comfortable with this," Sandoval said. "But this is the law, and it's not going to change, and we're going to ensure that there's compliance with it."

"It is going to take some time, but I think over time everyone is going to see it's in the best interest of the patient."

Contact Kimber Laux at klaux@reviewjournal.com. Follow @lauxkimber on Twitter.

AB 474 of 2017 – Sec. 3
effective Jan 1, 2018

- Cases of **drug overdose or suspected overdose** must be reported to the **Chief Medical Officer** by the provider of health care who knows of, or provided services to, the person.
- Any provider who willfully fails, neglects or refuses to comply is guilty of a misdemeanor and may be subject to an administrative fine of $ 1000 for each violation, as determined by the Board of Health.

Public Health - New Emergency Regulation

For the purpose of this regulation, a drug overdose or suspected drug overdose is reportable if the suspected drug is scheduled I, II, III, or IV per the United States Drug Enforcement Administration.

No later than 7 days from patient **discharge**, a provider of health care who knows of, or provides services to, a patient who has suffered or is suspected of having suffered a drug overdose shall report that fact to the Chief Medical Officer or his or her designee.

Public Health New Emergency Regulation

The name, address and telephone number of the health care provider making the report.

The name, address, and telephone number of the patient.

The occupation, employer, age, sex, race and date of birth of the patient.

The date of the overdose or suspected overdose.

Any laboratory results, including toxicology, that apply to the overdose or suspected overdose, as well as the description of the laboratory sampling method.

Disposition of the patient.

Previous known overdose(s) of the patient.

Patient pregnancy status.

International Classification of Disease (ICD) 10 Diagnosis Codes related to the overdose or suspected overdose.

State of Nevada
Overdose Reporting Form

Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Provider

Attending Physician	Physician Phone	Physician Fax
Person Reporting/Job Title	**Reporter Phone**	**Reporter Fax**
Facility Name	**Facility Phone**	**Report Date**

Patient

Name			Sex		Race	
				Female ☐		White ☐
Address		County		Male ☐		Black ☐
			Transgender	No ☐		Asian ☐
City	State	Zip		Yes, MF ☐		Native American ☐
				Yes, FM ☐		Pacific Islander ☐
Primary Phone		Social Security Number	Pregnancy EDC	Unknown ☐		Other ☐
					Ethnicity	
					Hispanic ☐	Non-Hispanic ☐
Date of Birth		Marital Status			Occupation	
		Single ☐	Married ☐	Widowed ☐		
		Divorced ☐	Separated ☐	Unknown ☐		

Medical Information

Disposition of Patient	Previous Known Overdose?		Date of overdose or suspected overdose
		Yes ☐	
		No ☐	
		Unknown ☐	
Was laboratory testing ordered?	Yes ☐ Attach Results	Medical Record Number	
	No ☐		

List the International Classification of Disease (ICD) 10 Diagnosis Codes related to the overdose or suspected overdose.

Notes

Fax completed form to the Nevada Division of Public and Behavioral Health at 775-684-5999

AB 474 of 2017 – Sec. 13, NRS 629.061
effective Jan 1, 2018 – Medical Record (MR) production

- Law enforcement or board investigator declaring **exigent circumstances** requires provider's **immediate** production of medical records (at the time of the request); if MRs are out of State, 5 days. (Sec. 13)
- Regular production of MRs by the **custodian of MRs** is 10 days (20 days if out of State).

See SB 291 (2017)

AB 474 of 2017 – all 6 Boards effective Jan 1, 2018

Each (of the six) Board shall, by regulation, require each practitioner certified or registered to **dispense** CS to complete **2 hours of training relating to the misuse and abuse of CS, the prescribing of opioids or addiction during each relicensure period**.

These CMEs may be used to satisfy 2 hours of <u>any</u> continuing education requirement.

(FYI, AB 105, effective July 1, 2017, requires 2 CME hours every four (4) years in suicide prevention.)

NBME Regulation 163-17

Licensee registered to **dispense** CS shall, each licensing cycle, complete at least 2 hours of Category I CME relating specifically to the misuse and abuse of CS, the prescribing of opioids or addiction.

NBOM Regulation 116-17

NAC 633.250:

Each osteopathic physician and PA, for licensure renewal, must attest he or she has completed 2 hours continuing education related to misuse and abuse of CS, the prescribing of opioids or addiction.

Each osteopathic physician shall complete 2 hours instruction on evidence-based suicide prevention and awareness every 4 years.

NBME Existing Mandate to Report Violations

NRS 630.3062 The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

6. **Failure to report any person** the licensee knows, or has reason to know, **is in violation of the provisions of this chapter or the regulations of the Board** within 30 days after the date the licensee **knows or has reason to know** of the violation.

NRS 630.3062 The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

3. Making or filing a report which the licensee knows to be false, **failing to file a** record or **report as required by law** or knowingly or willfully obstructing or inducing another to obstruct such filing.

NBOM Existing Mandate to Report Violations

NRS 633.511(1) The grounds for initiating disciplinary action pursuant to this chapter are:

(p) **Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.**

(o) Making or filing a report which the licensee knows to be false, **failing to file a record or report that is required by law** or knowingly or willfully obstructing or inducing another to obstruct the making or filing of such a record or report.

Controlled Substances

- Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules.

- Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused.

Schedule II - Controlled Substances

- Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.
- Examples of Schedule II narcotics include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®). Other Schedule II narcotics include: morphine, opium, codeine, and hydrocodone.
- Examples of Schedule IIN stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®)
- Other Schedule II substances include: amobarbital, glutethimide, and pentobarbital.

Schedule III - Controlled Substances

- Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

- Examples of Schedule III narcotics include: products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®), and buprenorphine (Suboxone®).

- Examples of Schedule IIIN non-narcotics include: benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as Depo®-Testosterone.

Schedule IV - Controlled Substances

- Substances in this schedule have a low potential for abuse relative to substances in Schedule III.

- Examples of Schedule IV substances include: alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

AB 474 of 2017

effective Jan 1, 2018 – Sec 57, NRS 639.23915

Before prescribing a CS (II, III, IV), **a practitioner must consider** the following factors, when applicable:

1. Whether there is reason to believe that the patient is not using the CS as prescribed or is diverting the CS for use by another person.
2. Whether the CS has had the expected effect on the symptoms of the patient.
3. Whether there is reason to believe that the patient is using other drugs, including alcohol, Schedule I CS or prescription drugs that:
   a. May interact negatively with the CS prescribed; or
   b. Have not been prescribed by a practitioner who is treating the patient.

AB 474 of 2017

effective Jan 1, 2018 – Sec 57

Before prescribing a CS (II, III, IV), a practitioner must **consider** the following factors, when applicable:

4. The number of attempts by the patient to obtain an early refill of the prescription.

5. The number of times the patient has claimed that the controlled substance has been lost or stolen.

6. Information from the PMP that is irregular or inconsistent or indicates that the patient is inappropriately using a CS.

7. Whether previous blood or urine tests have indicated inappropriate use of CS by the patient.

AB 474 of 2017

effective Jan 1, 2018 – Sec 57

Before prescribing a CS (II, III, IV), a practitioner **must consider** the following factors, when applicable:

8. The necessity of verifying that CS, other than those authorized under the treatment plan, are not present in the body of the patient.
9. Whether the patient has demonstrated aberrant behavior or intoxication.
10. Whether the patient has increased his or her dose of the CS without authorization by the practitioner.
11. 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 dependency or addiction.
12. Whether the patient has been reluctant to cooperate with any examination, analysis or test recommended by the practitioner.
13. Whether the patient has a history of substance abuse.

AB 474 of 2017

effective Jan 1, 2018 – Sec 57

Before prescribing a CS (II, III, IV), a practitioner **must consider** the following factors, when applicable:

14. Any major change in the health of the patient, including, pregnancy, or any diagnosis concerning the mental health of the patient that would affect the medical appropriateness of prescribing the CS for the patient.

15. Any other evidence that the patient is chronically using opioids, misusing, abusing, illegally using or addicted to any drug or failing to comply with the instructions of the practitioner concerning the use of the CS.

16. Any other factor that the practitioner determines is necessary to make an informed professional judgment concerning the medical appropriateness of the prescription.

AB 474 – Sec 60, NRS 639.23507

PMP Mandate – Before prescribing

Practitioner must obtain a PMP utilization report on the patient **before issuing** an initial prescription for a CS (II, III, IV) **and** at least **every 90 days** thereafter.

The practitioner shall:

a. Review the PMP report to access whether the prescription for the CS is medically necessary, and

b. Determine whether the patient has been issued another prescription for the same CS **for ongoing treatment; if so, the practitioner shall not prescribe the CS**.

AB 474 of 2017

effective Jan 1, 2018 – Prescription details

Each prescription for Controlled Substances (CS) II, III, and IV must include:

i. DEA number of the prescriber

ii. ICD 10 diagnosis

iii. Fewest number of days to consume the quantity of CS prescribed; number of refills, and

iv. Each state in which the patient to whom the CS was prescribed has resided or filled a prescription for CS II, III, or IV.

(see AB474 Sec. 7(e)(2); however, this is not required in sec. 61 of AB474 which amends NRS 639.2353 of the BOP statutes, but it is required in the **prescription medication agreement** nevertheless)

Controlled Substance (CS) NOT for Pain

1. 16 considerations before prescribing
2. Check the PMP (and every 90 days thereafter)
3. Review the PMP report to access whether the prescription for the CS is medically necessary
4. Determine whether the patient has been issued another prescription for the same CS for **ongoing treatment**; if so, the practitioner **shall not prescribe the CS**
5. Prescription: ICD 10 Diagnosis code; DEA # is clear; Minimum **days** to consume at maximum dosage

AB 474 of 2017

effective Jan 1, 2018 – Sec 53 & NRS 639.235(4), NRS 639.23911

Before issuing an **initial** prescription for CS (II, III, IV) for the treatment of pain, a practitioner must:

a. Have established a **bone fide relationship** with the patient

(a bona fide relationship between the patient and the person prescribing the controlled substance shall be deemed to exist if the patient was examined in person, electronically, telephonically or by fiber optics, including, without limitation, through telehealth, within or outside this State or the United States by the person prescribing the controlled substances within the 6 months immediately preceding the date the prescription was issued)

AB 474 of 2017
effective Jan 1, 2018 – Sec 53, 54, NRS 639.23912

Before issuing an **initial** prescription for CS (II, III, IV) for the treatment of pain, a practitioner must:

b. Perform an **evaluation and risk assessment** which must include:

1. Obtaining and reviewing a **medical history**
2. Conducting a **physical exam**
3. Make a **good faith** effort to obtain and review the **MRs from any other provider** who has provided care to the patient
   - practitioner shall document efforts to obtain such MRs
   - and the conclusions from reviewing these MRs
4. Assess the **mental health** and **risk of abuse, dependency and addiction of the patient**
   - using methods supported by peer-reviewed scientific research and validated by a nationally recognized organization

AB 474 of 2017

effective Jan 1 2018

- ✓ "physical exam" is not limited
  - ❖ dentists, optometrists, podiatrists
    - ❖ Not within the scope of practice

- ✓ Mental health test
  - ❖ Beck's depression inventory
- ✓ Test for risk of abuse, dependency and addiction
  - ❖ POMI (Prescription Opioid Misuse Index)

AB 474 of 2017

effective Jan 1, 2018 – Sec 53, NRS 639.23911

Before issuing a prescription for a CS (II, III, IV) for the treatment of pain, a practitioner **must**:

c. Establish a **preliminary diagnosis** of the patient and a **treatment plan** tailored toward treating the pain of the patient and the cause of that pain;

d. Document in the MR the **reasons for prescribing the CS instead of an alternative treatment** that does not require the use of a CS; and

AB 474 of 2017

effective Jan 1, 2018 – Sec 53, 54

e. Obtain **informed consent** to use a CS for the treatment of pain from:

i. The patient, if the patient is 18 years of age or older or legally emancipated and competent to give such consent;

ii. The parent or guardian of a patient who is less than 18 years of age and not legally emancipated; or

iii. The legal guardian of a patient of any age who has been adjudicated mentally incompetent.

AB 474 of 2017
effective Jan 1, 2018 – Sec 53, 54, NRS 639.23912

The **informed consent** must include information concerning:

1. potential risks and benefits of treatment using the CS
   - ➢ including if a form of the CS that is designed to deter abuse is available
   - ➢ the risks and benefits of using that form
2. proper use of the controlled substance
3. any alternative means of treating the symptoms of the patient and the cause of such symptoms
4. the important provisions of the treatment plan established for the patient

AB 474 of 2017
effective Jan 1, 2018 – Sec 53, 54

The **informed consent** must include:

5. the risks of dependency, addiction and overdose during treatment using the CS
6. methods to safely store and legally dispose of the CS
7. the manner in which the practitioner will address requests for refills of the prescription
8. if the patient is a woman between 15 and 45
   - the risks to a fetus of chronic exposure to CS during pregnancy
   - the risks of fetal dependency on the CS and neonatal abstinence syndrome

AB 474 of 2017
effective Jan 1, 2018 – Sec 53, 54

The **informed consent** must include:

9. if the CS is an opioid
   - the availability of an opioid antagonist without a prescription, and
   - if the patient is an unemancipated minor
     - the risks that the minor will abuse or misuse the CS or divert the CS for use by another person, and
     - ways to detect such abuse, misuse or diversion

AB 474 of 2017

effective Jan 1, 2018 – Sec 52

Pain Treatment with a CS – including an opioid

For treatment of **acute pain**, shall not prescribe CS for more than 14 days and, **if** the CS is **an opioid**, if patient has never been issued an opioid or it has been more than 19 days since initial prescription for an opioid, prescription **may not exceed 90 MMEs per day**.

AB 474 of 2017

effective Jan 1, 2018 – Sec 53, 54

If a practitioner prescribes a **CS (II, III, IV) for the treatment of pain**, the practitioner shall not issue more than one additional prescription that increases the dose of the CS unless the practitioner meets with the patient, in person or using telehealth, to reevaluate the treatment plan.

Initial Prescription for CS (II, III, IV) for Pain

Same as not for pain, plus:

- ✓ If **acute pain**, CS for no more than 14 days and no more than 90 MMEs if opioid naïve
- ✓ Bone fide relationship
- ✓ Evaluation and risk assessment
  - i. Medical **history**
  - **ii. Physical** exam
  - iii. Document **good faith** effort to obtain and review prior medical records, and document conclusions of review in patient's MRs

Initial Prescription for CS (II, III, IV) for Pain

iv. Access **mental health** and **risk of abuse**, dependency, and addiction with qualifying tests

- ✓ **Preliminary diagnosis** and **treatment plan** to treat the patient's pain and the cause of the patient's pain
- ✓ Document in the MR the **reasons for prescribing the CS instead of an alternative treatment** that does not require the use of a CS

Initial Prescription for CS (II, III, IV) for Pain

- ✓ Obtain an **informed consent** to use a CS for the treatment of pain from the appropriate authority (person, parent, legal representative)
  - ✓ The informed consent must include the eight (8) required elements, plus, if an opiate, four (4) additional elements.

No more than one increase in the CS unless re-evaluation of treatment plan in-person or telehealth

AB 474 of 2017

effective Jan 1, 2018 – Sec 56, NRS 639.23914
Pain Treatment using a CS for > 30 days

If a practitioner intends to prescribe a controlled substance (II, III, IV) for **more than 30 days** for the treatment of **pain**, the practitioner must, not later than 30 days after issuing the initial prescription, enter into a **prescription medication agreement** with the patient, which must be:

Documented in the patient's MRs; and updated at least once every 365 days while the patient is using the CS, or updated whenever a change is made to the treatment plan.

AB 474 of 2017

effective Jan 1, 2018 – Sec 56
Pain Treatment using a CS

A **prescription medication agreement** must include:

a. The **goals of the treatment** of the patient

b. **Consent** of the patient to testing **to monitor drug use when deemed medically necessary by the practitioner**;

c. A requirement that the patient **take the CS only as prescribed**;

d. A **prohibition on sharing medication with any other per**son;

AB 474 of 2017

effective Jan 1, 2018 – Sec 56

Pain Treatment using a CS > 30 days

A **prescription medication agreement must include:**

e. A requirement that the **patient inform the practitioner:**

i. Of **any other CS prescribed to or taken** by the patient;

ii. **Whether the patient drinks alcohol or uses marijuana or any other cannabinoid** while using the CS

iii. Whether the patient has been treated for side effects or complications relating to the use of the CS, including whether the patient has experienced an overdose; and

iv. **Each state** in which the patient has previously resided **or** had a prescription for a CS filled;

AB 474 of 2017

effective Jan 1, 2018 – Sec 56

Pain Treatment using a CS > 30 days

A **prescription medication agreement must** include:

f. Authorization for the practitioner to **conduct random counts of the amount of the CS in the possession of the patient;**

g. The **reason the practitioner may change or discontinue treatment** of the patient using the CS; and

h. Any other requirements that the practitioner may impose.

Using a CS for the treatment of pain for 30 days

Prescription Medication Agreement

- ✓ must contain all 10 elements (plus any additional desired by the practitioner)
- ✓ must be renewed every 365 days, and updated after any change in the treatment plan

AB 474 of 2017

effective Jan 1, 2018 – Sec 55

Pain Treatment using a CS > 90 days

Before prescribing a CS (II, III, IV) to continue **to treat pain** for **90 days or more**, a practitioner must:

a. Require the patient to **complete an assessment of the patient's risk for abuse**, dependency and addiction that has been validated through peer-reviewed scientific research;

b. Conduct an investigation, including appropriate hematological and radiological studies, to determine an **evidence-based diagnosis** for the cause of the pain;

AB 474 of 2017

effective Jan 1, 2018 – Sec 55

Pain Treatment using a CS > 90 days - including opioid

Before prescribing a CS (II, III, IV) to continue **to treat pain** for **90 days or more**, a practitioner must:

c. Meet with the patient, in person or using telehealth, to review the treatment plan to **determine whether continuation of treatment using the CS is medically appropriate**; and

d. If the patient has been prescribed a dose of 90 MMEs or more of an **opioid** per day for 90 days or longer, consider referring the patient to **a specialist**

AB 474 of 2017

effective Jan 1, 2018 – Sec 52, NRS 639.2391
Pain Treatment using a CS

If practitioner prescribes more than 365 days of CS **pain medication** (II, III, IV) in 365 days, practitioner must document in MR the reasons, or

for a larger quantity of CS (II, III, IV) than will be used in 90 days, the prescriber must document in the MR the reasons.

AB 474 of 2017

effective Jan 1, 2018 – Sec 55

Pain Treatment using an opioid

If the practitioner decides to continue to prescribe a dose of 90 MMEs or greater per day, the practitioner must develop and document in the patient's MRs **a revised treatment plan with must include an assessment of the increased risk for adverse outcomes**.

Using a CS (II, III, IV) for the treatment of Pain 90 days

- ✓ complete another assessment for the patient's risk of abuse, dependency, or addiction (COMM test)
- ✓ conduct an investigation to determine an evidenced-based diagnosis for the cause of the pain
- ✓ meet with patient, in-person or telehealth, to determine whether continuation with a CS for the treatment of pain is medically appropriate
- ✓ if patient is on a dose of 90 MMEs or greater, consider referring to **a specialist**
- ✓ if continuing 90 MMEs or >, document in MR the revised treatment plan, including risk for adverse outcomes

AB 474 of 2017

effective Jan 1, 2018 – Sec 9

- Board of Pharmacy (BOP) may access the PMP to identify any suspected fraudulent, illegal, unauthorized activity related to prescribing, dispensing, or use of a CS.
- Discovered information shall be reported to law enforcement or licensing board.
- **Dispensing** Licensees must present proof of authorization to access the PMP to be relicensed.

AB 474 of 2017

effective Jan 1, 2018 – all 6 Boards

Failure to comply with requirements of NRS 453.163, 453.164, 639.23507, and sections 52 to 58 of AB 474, and any regulations adopted by the BOP, subjects the licensee to licensure discipline.

Fraudulent, **illegal**, unauthorized or otherwise **inappropriate** prescribing, administering or dispensing of a CS subjects the licensee to licensure discipline.

AB 474 of 2017

effective Jan 1, 2018 – all 6 Boards

If licensing Board **Executive Director** (ED) receives complaint from law enforcement, BOP, or any other source, that the licensee has:

- has issued a fraudulent, illegal, unauthorized or inappropriate CS prescription, or
- a pattern of such prescribing, or
- **a patient (of the licensee) who has acquired, used or possessed a CS (II thru IV) as above**, then:

AB 474 of 2017 – all 6 Boards

effective Jan 1, 2018 – "review and evaluation"

- ED, or designee, must notify licensee as soon as practicable (may delay notification if criminal investigation ongoing)
- ED, or designee, reviews PMP licensee's information
- the licensee is required to **attest** that licensee has complied with NRS 639.23507 (reviewed patient's PMP and CS is medically indicated; confirm if ongoing treating CS not written by another prescriber) AND has complied with AB 474 sec. 52, 54, and 57.

AB 474 of 2017 – all 6 Boards
effective Jan 1, 2018

After "review and evaluation," **if ED, or designee, determines** that the licensee **may** have issued a fraudulent, illegal, unauthorized or inappropriate prescription, the ED, or designee, may refer for criminal prosecution & the Board must **proceed as if a written complaint had been filed** against the licensee.

After conducting an investigation and a hearing, if licensee is found guilty, the licensing Board must impose appropriate disciplinary action.

AB 474 of 2017 – all 6 Boards
effective Jan 1, 2018 – Sec 34

If the Board determines from investigation that the public health, safety, or welfare, of any patient is at risk of imminent or continued harm, the Board **may** summarily suspend licensee's authority to prescribe CS (II, III, IV) pending a determination upon the conclusion of a hearing to consider a formal complaint against the licensee.

AB 474 of 2017 – all 6 Boards
effective Jan 1, 2018 – Sec 34

Such summary suspension may be issued by the Board, **President of the Board**, presiding officer of an investigative committee (IC) conducting the investigation or member of the Board who conducted the investigation. If IC chair or investigating member issues the summary suspension order, that person may not participate in any further proceedings related to the order.

The licensing Board must hold a hearing and render a decision **concerning [whether to file] the formal complaint** within **60 days** of the summary suspension order for the Medical Board, Nursing Board, Podiatric Board, and Optometric Board, or within **180 days** for Osteopathic Medical Board and Dental Board.

AB 474 of 2017 – all 6 Boards effective Jan 1, 2018

The **licensing Board** shall adopt **regulations** providing for disciplinary action against a licensee for inappropriately prescribing a CS (II, III, IV) **or** violation of Section 52 to 58 of AB 474, and any regulations of the BOP, to include additional continuing education concerning prescribing CS II, III, IV.

AB 474 of 2017

effective Jan 1, 2018 – Sec 58; NRS 630.23916

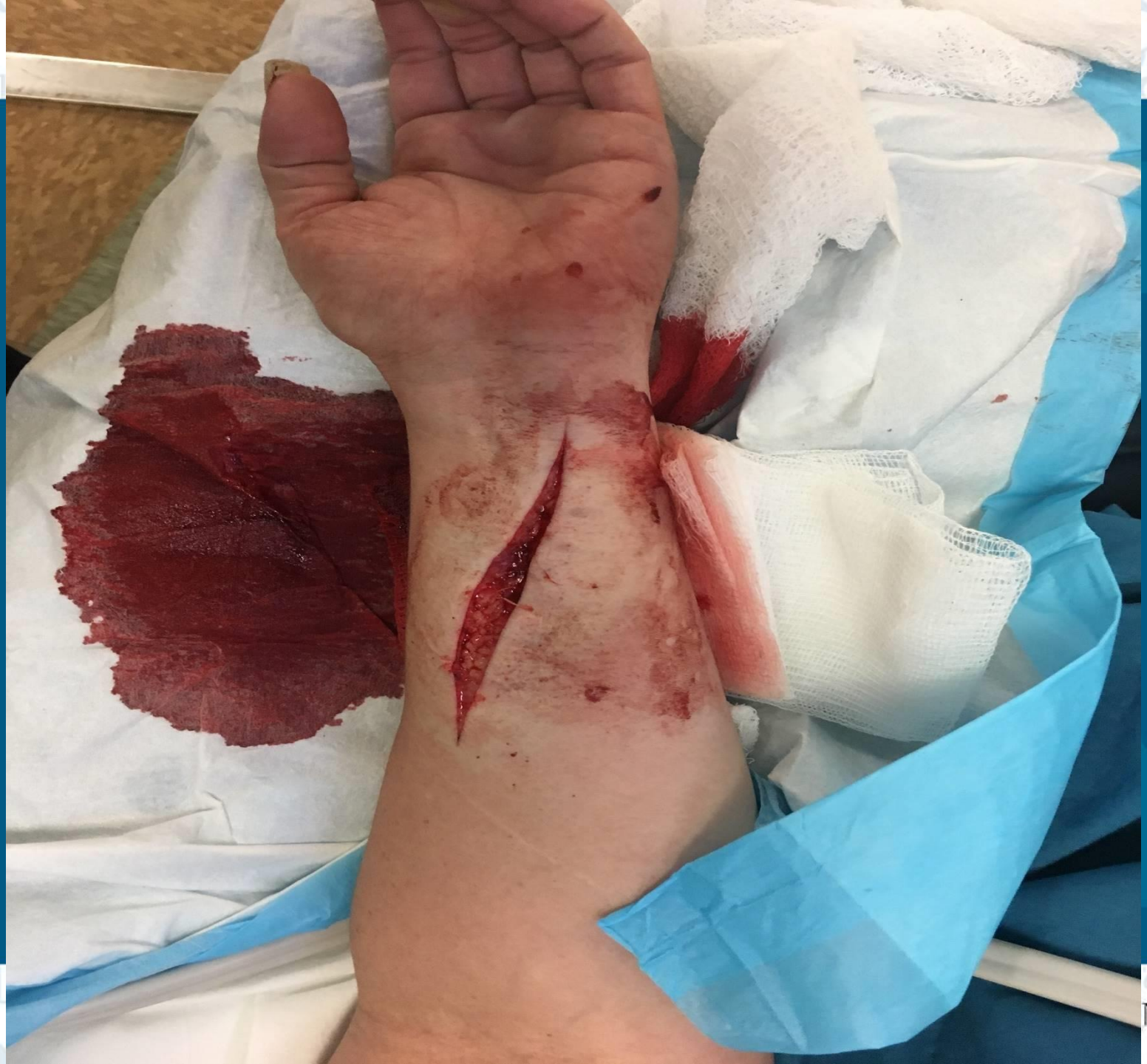
The BOP may adopt any regulations necessary or convenient to enforce the provisions of NRS 639.23507, and Sections 52 to 58 of AB 474. Such regulations may impose additional requirements concerning the prescription of CS II, III, IV **for the treatment of pain.**

A practitioner who violates any provision of this act or any furthering regulations is:

a. Not guilty of a misdemeanor; and [is]

b. Subject to professional discipline.

Thank God He Stopped Talking!!!



Nevada