53 N.J.R. 619(c)

VOLUME 53, ISSUE 8, APRIL 19, 2021

RULE ADOPTIONS

Reporter
53 N.J.R. 619(c)

NJ - New Jersey Register > 2021 > APRIL > APRIL 19, 2021 > RULE ADOPTIONS > LAW AND PUBLIC SAFETY -- DIVISION OF CONSUMER AFFAIRS

Agency

LAW AND PUBLIC SAFETY > DIVISION OF CONSUMER AFFAIRS > STATE BOARD OF DENTISTRY

Administrative Code Citation

Adopted Amendments: N.J.A.C. 13:30-1.2, 1.5, 1A.2, 1A.4, 1A.5, 1A.7, 2.2, 2.3, 2.7, 2.8, 3, 5, 6.2, 8.1, 8.2, 8.3, 8.4, 8.7, 8.8, 8.9, 8.10, and 8.26

Adopted Repeal and New Rule: N.J.A.C. 13:30-8.6

Adopted New Rules: N.J.A.C. 13:30-8.5A, 8.6A, 8.6B, and 8.12A

Text

Board of Dentistry Rules

Proposed: November 18, 2019, at 51 N.J.R. 1648(a).

Adopted: September 2, 2020, by the State Board of Dentistry, Elizabeth Clemente, DDS, President.

Filed: March 12, 2021, as R.2021 d.035, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3), **with proposed N.J.A.C. 13:30-8.7(a)4 not adopted,**

and with the proposed amendments to N.J.A.C. 13:30-8.2(e) not adopted, but still pending.

Authority: N.J.S.A. 45:1-15 and 45:6-19.4; and P.L. 2007, c. 235, P.L. 2009, c. 221, P.L. 2013, c. 182, and P.L. 2017, c. 28.

Effective Date: April 19, 2021.

Expiration Date: October 11, 2024.

Summary of Public Comments and Agency Responses:

The official comment period ended on January 17, 2020. The Board of Dentistry (Board) received comments from:

1. Dorrie Gagnon, RDH, Kinder Smile Foundation;

2. Faith Occhiogrosso;

3. Michael A. Carey DMD;

4. Margarite Remsey, RDH, MS;

5. Rebecca Welch Pugh, Executive Director for the New Jersey Coalition on Oral Health for the Aging (NJCOHA);

6. Kevin Heaney, DDS, MPH;

7. Robert McTaggart DMD;

8. Dr. John F. Mielo, Round Valley Family Dentistry;

9. Gary White, DDS;

10. Ari Krug, DMD, Krug Orthodontics;

11. Robert P Praisner, DMD;

12. Hillel Ephros, DMD, MD, OMS Program Director and Chairman, Department of Dentistry/OMS with full agreement and consensus of core faculty members: Richard P. Szumita, DDS, Associate Program Director, OMS and Associate Chairman, Department of Dentistry/OMS; Michael [page=620] C. Erlichman, DDS, Assistant Program Director, OMS; Robert J. DeFalco, DDS, Attending Oral & Maxillofacial Surgeon; Meredith Blitz, DDS, Attending Oral & Maxillofacial Surgeon and former Director of Anesthesia, Department of OMS, Rutgers School of Dental Medicine; Henna DeSimone, DDS, Program Director, Pediatric Dentistry;

13. Benjamin Jacobs DMD, Diplomate, American Board of Oral & Maxillofacial Surgery;

14. Dr. Ronen Gold;

15. Lee C. Kojanis, DDS, Associate, Premier Oral Surgery Group PC, Assistant Clinical Professor, NYU/Bellevue Hospital Center, Attending, Englewood Hospital Medical Center;

16. Suzanne Gilman, DDS, FAGD, Esq.;

17. Paul J. Condello, DMD;

18. Michael DiPietro, DMD, Daniel Winston, DDS, and John Soliman, DMD, MD, Coastal Oral Surgery;

19. Daniel P. Sullivan, DDS, Warren Oral Surgery;

20. Jocelyn Jeffries-Bruno, DDS, President of the Monmouth-Ocean County Dental Society;

21. Petar Hinic, DDS, President, New Jersey Dental Society of Anesthesiology;

22. Ted Rosner, DMD;

23. Stuart S. Albin, DMD;

24. Dr. Elisa Velazquez, President of New Jersey Academy of Pediatric Dentists (NJAPD);

25. Paul J. Condello, DMD;

26. Manaf Saker, DMD, Ridgewood Oral Surgery & Implant Center;

27. Joseph J. Sansevere, West Jersey Oral and Maxillofacial Surgeons, PC., DMD;

28. Bradford J. Porter, DDS, Gene J. Martin, DDS, MD, and James B. Salman, DMD, Porter, Martin, Salman, P.A., Oral and Maxillofacial Surgery;

29. Dr. Caprice, Vineland Oral Surgeons, PA;

30. Dr. Leonard Infranco, DMD, Vineland Oral Surgeons, PA;

31. Dr. Palma, Vineland Oral Surgeons, PA;

32. Juan C. Alonso, DMD;

33. Michael K. Goulston, DMD, MD, FACS, Oral and Maxillofacial Surgery and Implant Specialists of Middlesex;

34. Lee M. Lichtenstein, DMD, MBA;

35. Arthur Meisel, Executive Director, on behalf of Thomas A. Rossi, DMD and the New Jersey Dental Association;

36. Katherine Landsberg, Director, Government Relations, Dental Assisting National Board, Inc.;

37. Cecile A. Feldman, DMD, Dean, Rutgers School of Dental Medicine;

38. Dr. Narpat Jain, DMD, President, New Jersey Academy of General Dentistry;

39. Torin W. Rutner, DMD, MD, Center For Oral & Facial Surgery;

40. Lillian Vidal DDS;

41. Edward Kozlovsky, DMD, Oral and Maxillofacial Surgeon;

42. Jonathan Mendia, DMD, Advanced Dental Anesthesia;

43. Gregg A. Jacob, DMD, FACS, Assistant Clinical Professor of Surgery, Department of Oral and Maxillofacial Surgery, New York Presbyterian Hospital, Weill-Cornell Medical College, Vice President, New Jersey Society of Oral and Maxillofacial Surgeons;

44. Muna Khan, DDS;

45. Dr. Juliet Siegel, ADA member dentist;

46. Alison Chan DDS;

47. Dr. Michael Grizzaffi, Member: NJDA, NJDSA and AGD;

48. Travis W. Reed, DMD, West Jersey Oral and Maxillofacial Surgeons, PC.;

49. Shahid R. Aziz, DMD, MD, FACS, FRCSED, President, and Alan Hecht, DMD, Chairman, Anesthesia Committee, Past President, of the New Jersey Society of Oral and Maxillofacial Surgeons;

50. John W. Vitale, DMD, Oral and Maxillofacial Surgery;

51. Philip M. Echo, DMD;

52. George W. Sandau, DMD, Westwood Oral Surgery Associates, P.A.;

53. Michael H. Kirsch, DDS, NJ Center for Oral Surgery; and

54. Kevin Corry, DDS, Vice Chair, Department of Dentistry, Overlook Medical Center.

Support

1. COMMENT: One commenter thanked the Board for the many changes that will benefit both dental patients and the professionals that care for

them. The commenter expressed support for the changes that will help clarify the rules and simplify administrative procedures for licensees.

RESPONSE: The Board thanks the commenter for its support.

2. COMMENT: One commenter commended the Board on the updated language used in the notice of proposal. The commenter stated that by using the current names of various agencies cited in the notice proposal, confusion is eliminated. The commenter also commended the Board on the inclusion of technology, such as the online jurisprudence orientation, which will facilitate actions needed by professionals licensed by the Board. In addition, the commenter stated that the extension of continuing education credits to professionals providing care to eligible persons (that is, NJ Family Care, seniors, and other eligibility standards) is commendable and will assist individual professionals in meeting needs in their communities. The commenter also stated that the defined continuing education requirements are appreciated and noted that CPR and infection control, as well as opioid education are real necessities for meeting the needs of seniors. The commenter further stated that the addition of the provision of radiographic exposures by dental hygienists in a school setting is commended as it is needed for a thorough assessment.

RESPONSE: The Board thanks the commenter for its support.

Examination

3. COMMENT: One commenter expressed support for the Board's proposed amendment that correctly identifies one of the required dental assisting examinations by changing it from "Registered Dental Assistant Certification Examination" to "Certified Dental Assistant Examination." The commenter requested that the Board also amend N.J.A.C. 13:30-2.2(b)2iv to similarly update the name of the examination.

RESPONSE: The Board thanks the commenter for its support. The Board, upon adoption, consistent with the changes proposed throughout the section, will change N.J.A.C. 13:30-2.2(b)2iv to correctly identify the name of the examination as the Certified Dental Assistant Examination.

4. COMMENT: One commenter recommended that the Board amend N.J.A.C. 13:30-1.2 to expand the administrators of the qualifying dental examination for licensure to include "such other entities as may be recognized by the Board."

RESPONSE: It is the Board's understanding that besides the Commission on Dental Competency Assessments, the only other agency that currently administers the ADEX examination is the Council of Interstate Testing Agencies (CITA). In addition, the Board understands that to be

recognized as an ADEX examining entity there must be adherence to the same exam content, criteria, and grading procedures. Accordingly, upon adoption the Board will change N.J.A.C. 13:30-1.2(b)3 to include other entities administering the ADEX examination. Additional public notice of this change is not necessary because it does not change the effect of this rule, so as to destroy the value of the original notice. The Board will continue to require the ADEX examination.

5. COMMENT: One commenter stated that because the ADEX examination is a standardized examination, the testing agency that administers the examination should not matter, and there is no reason to require the examination to be administered by the Commission on Dental Competency Assessments (CDCA). The commenter contended that requiring that the ADEX exam be administered solely by the CDCA could be construed as anticompetitive because individuals who would have taken and passed the ADEX exam administered by other testing agencies would be deemed ineligible for licensure, unless they meet the requirements for licensure by credentials. The commenter believes this is more of an issue for newer dentists and requiring that they retake the ADEX exam as administered by CDCA would be a significant burden, including a financial burden on these dentists.

The commenter stated that there are several alternative licensure examination options being developed, including an integrated national board, an Objective Structured Clinical Examination (OSCE) that assesses clinical abilities, an examination based upon a portfolio of clinical work and manikin simulation that more closely simulates the human dentition. The commenter believes that the Board should have the [page=621] authority to assess these alternative licensing examinations when they become available as they may have equivalent or even superior validity.

The commenter also noted that the Commission on Dental Competency Assessments (CODA) accredits pre-doctoral dental programs which grant DMD or DDS degrees, not dental schools, colleges, or departments of a university.

The commenter recommended that the Board amend N.J.A.C. 13:30-1.2(b)3 as follows (deletions in strikethrough):

> "Results from the successful completion of the ADEX dental examination, including the Periodontal Examination, or any other licensing examination approved by the Board
>
> administered by the Commission on Dental Competency Assessments. If an applicant fails any portion of the ADEX dental examination or other approved licensing examination approved by the Board three consecutive times, the Board may require the applicant to sit for,

and pass, a remedial course in the subject area at a pre-doctoral dental program

dental school, college, or department of a university approved accredited by the Commission on Dental Accreditation;"

RESPONSE: The Board continues to review different examination options for licensure as a dentist, including the Objective Structured Clinical Examination (OSCE). Any such changes will be considered in a separate rulemaking. In addition, upon adoption the Board will change N.J.A.C. 13:30-1.2(b)3 to include other entities administering the ADEX examination. (See the Response to Comment 4)

The Board agrees with the commenter that the Commission on Dental Accreditation accredits dental programs not dental schools. Accordingly, upon adoption the Board will change N.J.A.C. 13:30-1.2(b)3 to make this clarification.

Dental Hygienists Scope of Practice

6. COMMENT: One commenter recommended amending the settings at N.J.A.C. 13:30-1A.4 to include long-term care facilities. The commenter stated that numerous surveys cite the needs of seniors and noted that the American Dental Association (ADA) has indicated that 63 percent of seniors have no dental coverage. The commenter also stated that, in 2018, Oral Health America noted that New Jersey seniors ranked 44th out of 50 states in oral health. The commenter believes that there is little that can be done to improve this without being able to offer preventive care, as well as referrals to dentists for truly needed care in this population.

RESPONSE: The Board notes that in accordance with N.J.A.C. 13:30-1A.4(b) dental hygienists may perform certain functions in an institution, including making radiographic exposures and performing a prophylaxis, under the general supervision of a State licensed dentist. In accordance with N.J.S.A. 45:6-49 and N.J.A.C. 13:30-1A.1, an "institution" means any nursing home, veterans' home, hospital, or prison, or any State or county facility providing inpatient care, supervision, and treatment for persons with developmental disabilities. The Board does not have the statutory authority to broaden the locations encompassed by the term "institution."

7. COMMENT: One commenter asked the Board to consider allowing x-rays to be taken in the out-patient/mobile setting for students and providers.

RESPONSE: Proposed N.J.A.C. 13:30-1A.4(c)2 allows licensed dental hygienists practicing under the general supervision of a licensed dentist in a school setting to make radiographic exposures as permitted

by the Department of Environmental Protection pursuant to N.J.S.A. 26:2D-24 et seq., provided that the exposures are made for the school's students and written parental or guardian consent is obtained.

8. COMMENT: One commenter recommended that the Board amend N.J.A.C. 13:30-1A.4(c)2 to delete the word "shall" and replace it with "may" and to read as follows:

> "May make radiographic exposures as authorized by the supervising licensed dentist provided that the exposures are made only to students who attend the school and written parental or guardian consent is obtained."

The commenter believes that there may be times when radiographs are contra-indicated.

RESPONSE: The Board's use of "shall" refers to the conditions under which radiographic exposures may be made and does not require dental hygienists to make such exposures. Upon adoption the Board will change N.J.A.C. 13:30-1A.4(c)2 to clarify the language.

9. COMMENT: One commenter recommended that the Board consider implementing a public dental hygienist role to help the underserved communities and special needs population with their oral health.

10. COMMENT: One commenter stated that it is time to improve access to dental care. The commenter stated that dental hygienists are well educated and trained to provide many dental services. The commenter requested that the Board expand their ability to reach the public.

RESPONSE TO COMMENTS 9 AND 10: To the extent permitted by law, the Board continues to improve and expand access to dental care. New Jersey law, N.J.S.A. 45:6-48 et seq., requires a dental hygienist to work under the supervision of a licensed dentist. Thus, the Board does not have the statutory authority to establish a public dental hygienist role allowing the provision of dental hygiene services without the supervision of a dentist in a public health setting.

Limited Teaching Certificate in a Dental School

11. COMMENT: One commenter contended that proposed N.J.A.C. 13:30-3.4(c) would permit the creation of dental schools that do not meet current minimal standards.

The commenter stated that CODA is authorized by the U.S. Department of Education to accredit dental program in the United States and the Commission on Dental Accreditation of Canada (CDAC) accredits dental programs in Canada, and that there is a reciprocal accreditation arrangement between the CODA and CDCA. The commenter stated that, under

the reciprocal agreement, the Commissions recognize the accreditation of pre-doctoral education programs accredited by the other agency and agree that the educational programs accredited by the other agency are equivalent to their own and no further education is required for eligibility for licensure. The commenter stated that CODA also requires that the programs be sponsored by a parent university that is accredited by one of the regional accrediting agencies recognized by the U.S. Department of Education. The commenter stated that these accreditation standards ensure that the pre-doctoral program meets minimal education program quality standards.

The commenter contended that the Board's proposed language permits the creation of U.S. pre-doctoral dental programs that do not meet either dental program accreditation standards and/or regional accreditation standards for the sponsoring college or university. The commenter stated that a program's location within the United States, Canada, or a territory or possession of the United States does not mean that a program meets minimal program standards. The commenter averred that, by requiring that the program be accredited by CODA or CDAC, the licensing agency can have confidence that the candidate graduated from a program that meets such minimal specialized professional standards.

The commenter recommended that the Board amend the language as follows (deletions in strikethrough):

> "For the purposes of this subsection, if the pre-doctoral dental program is accredited by the Commission of Dental Accreditation (CODA) or the Commission of Dental Accreditation of Canada
>
> dental school from which the applicant graduated and is located in the United States, Canada, or a territory or possession of the United States, the dental school the applicant shall be deemed as having graduated from a dental school approved by the Board.

The commenter stated that the revised wording would still enable the Board to approve other programs.

RESPONSE: In accordance with N.J.S.A. 45:6-16.2(b), N.J.A.C. 13:30-3.4(c) states that the Board must approve a dental school located in the United States, Canada, or a territory or possession of the United States.

Continuing Education Requirements

12. COMMENT: One commenter expressed support for the Board amending N.J.A.C. 13:30-5.1 to require continuing education for opioid medications because of the opioid epidemic in this country and, specifically, in New Jersey. The commenter also agreed with the Board [page=622] mandating every New Jersey licensed dentist receive Basic

Life Support (BLS) training and certification as it is paramount for patient safety.

RESPONSE: The Board thanks the commenter for its support.

13. COMMENT: One commenter agreed with the Board's intention on altering the requirements for continuing education because they will enhance patient safety through a better-informed profession.

RESPONSE: The Board thanks the commenter for its support.

14. COMMENT: One commenter recommended that the Board include in its continuing education requirements cardiopulmonary resuscitation (CPR) training, and professional ethics and the New Jersey law concerning the practice of dentistry. The commenter noted that, although cardiac emergencies and choking are rare, they are foreseeable events in a dental office. The commenter, therefore, believes that CPR training should be a continuing education requirement for all dental professionals. In addition, the commenter stated that it is the Board's responsibility to protect the public. In addition, the commenter believes that most dental professionals do not understand the laws that affect their treatment of patients and, therefore, believes that one hour of professional ethics and New Jersey law concerning the practice of dentistry should be integral to the Board's continuing education requirements.

RESPONSE: The Board thanks the commenter for its support of its rule proposal to require licensed dentists and dental hygienists and registered dental assistants and limited registered dental assistants in orthodontics to take continuing education in practical hands-on certification for CPR and professional ethics and New Jersey law concerning, as applicable, the practice of dentistry, dental hygiene, or dental assisting.

15. COMMENT: One commenter expressed concerns with the continuing education requirements for dentists and hygienists. The commenter stated that neither care nor consideration is given as to whether these courses even exist and are readily available. The commenter also stated that there is no remedy provided for scheduling limitations, wherein a limited course-selection by educational providers will prevent satisfactory completion of the requirements. The commenter further stated that the Board rigidly mandates training for dentists that may not be applicable to their practices. The commenter questioned, for example, why a dentist should be forced to take a heavy predominance of "Opioid" training, if the dentist does not even prescribe opioids. The commenter believes that the decision should be left to the individual doctors to attain education pertinent to their practices. The commenter

also stated that no evidence exists in any context, that dentists bear any responsibility for the current "Opioid Crisis."

16. COMMENT: One commenter stated that if a dentist does not prescribe opioids and does not have a Drug Enforcement Administration (DEA) license, the dentist should not need to take any opioid continuing education in that subject. The commenter believes that the Board is making continuing dental education cookie cutter and asked that the Board not take freedom of choice away from dentists.

17. COMMENT: One commenter stated that many dentists, especially those in the practice of orthodontics, do not have use for opioid prescription writing and, therefore, many of these practitioners do not keep active DEA licensure or State-controlled substance writing privileges. The commenter believes that it would make sense that the proposed continuing education requirements in these areas not be applicable to dentists who voluntarily do not keep this privilege active. The commenter also stated that registered dental assistants who exclusively work in these offices should also be exempt from this requirement.

RESPONSE TO COMMENTS 15, 16, AND 17: Proposed N.J.A.C. 13:30-5.1(e)5 implements State law, N.J.S.A. 45:6-10.2a, which requires each licensed dentist, as a condition of biennial licensure, to take one hour of continuing education in educational programs or topics concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion. Consistent with the law, if the Board deems it appropriate, on an individual basis, the Board may waive the specific one credit continuing education requirement concerning prescription opioid drugs.

The Board believes that this required continuing education is important for overall patient care and awareness of patient health because it is not solely about the prescribing of opioids but also recognizing the signs of addiction, addiction patterns, and drug-seeking behavior. Accordingly, the Board has determined that licensed dental hygienists and registered dental assistants must also take at least one credit of continuing education in educational programs or topics concerning prescription opioid drugs.

18. COMMENT: One commenter noted that continuing education programs in pharmacology typically address the subject of prescription opioid drugs. The commenter, therefore, urged the Board, to promote consistency and reduce redundancy, to amend N.J.A.C. 13:30-5.1(e) to require 9, rather than 10, hours of designated biennial continuing

education in prescribed subject areas by combining pharmacology and opioid education. The commenter recommended the following language:

> "A minimum of three hours of continuing education of pharmacology and internal medicine, which includes the appropriate use of analgesics, antibiotics, local anesthesia and agents to control anxiety, drug (medication) knowledge and interactions, prescription writing, abuse of prescriptions by patients, taking complete medical histories, and the use of the New Jersey Prescription Monitoring Program (NJPMP); provided that no less than one hour of the program shall include continuing education in educational programs or topics concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion. The one credit regarding opioid drugs shall not be eligible for carry-over as described in (k) below."

19. COMMENT: One commenter believes that it is redundant and impractical to require pharmacology continuing education for dentists. The commenter stated that throughout their advanced training, dentists have acquired knowledge of medical pharmacology that prevents detrimental drug interactions, as well as the knowledge that allows them to safely treat patients.

RESPONSE TO COMMENTS 18 AND 19: The Board believes that, because the drug spectrum is so variant and is constantly changing, three credits of pharmacology and one credit of opioid continuing education are necessary for patient well-being, care, and safety.

20. COMMENT: One commenter stated that the use of the word "must" with respect to continuing education courses does little to benefit patient safety. The commenter questioned the sense in requiring everyone, including seasoned dentists who have been exposed repeatedly to courses in infection control, pharmacology, ethics, opioid drugs, regardless of their training and experience to repeat courses to which nothing will change with the dentist's conduct. The commenter contended that using the word "must" gives liability attorneys a statute to enforce against dentists, or for the Board to enforce a penalty, at its discretion.

RESPONSE: The Board believes that the required continuing education topics at N.J.A.C. 13:30-5.1(e)1 are those that, at a minimum, are necessary for licensed dentists to keep current about important developments in the field.

21. COMMENT: One commenter believes that it is unnecessary and redundant to require mandatory continuing education in ethics, given that dentists take a jurisprudence exam prior to becoming licensed in

the State of New Jersey and receive ethics as a component of their dental education.

RESPONSE: The Board believes that it is important for licensed dentists to keep abreast of ethical considerations and changes to New Jersey laws, rules, and regulations.

22. COMMENT: One commenter stated that it is unnecessary and redundant to require Federal Occupational Safety and Health Administration (OSHA) continuing education because dentists must already comply with OSHA standards that allow them to treat patients safely and effectively in a traditional setting. The commenter stated that dental offices are already required to complete training in OSHA, as stated by the U.S. Department of Labor, OSHA Bloodborne Pathogens Standard and annual training is held for all team members involved with direct patient interaction as noted below. The commenter also stated that because dentists are employees of the practice, they already fall under these guidelines. The commenter noted that the ADA has the following policy regarding mandatory OSHA training:

> "The Federal Occupational Safety and Health Administration (OSHA) Hazard Communication Standard (HCS) states that [page=623] you must provide mandatory employee training to improve your staff's understanding of the chemical hazards in your office and learn how to handle chemicals appropriately. Employees should be trained on the type of information they will see on labels, how they might use the labels in an office setting and how all the elements of the label work together. You will also need to train employees to understand Safety Data Sheets (SDS), including the type of information found and how the label information relates to the SDS." https://success.ada.org/en/regulatorylegal/mandatory-osha-training

RESPONSE: The Board's continuing education requirements for dentists, dental hygienists, and registered dental assistants and limited registered dental assistants in orthodontics at N.J.A.C. 13:30-5.1(e)1ii, 5.2(a)1ii, and 5.3(f)2, respectively, are necessary to ensure public safety. Based upon the Board's experience, the Board believes there is a need in the profession to keep current about infection control procedures beyond any Federal requirements for OSHA and Centers for Disease Control and Prevention (CDC) training.

23. COMMENT: With respect to the proposed continuing education requirements at N.J.A.C. 13:30-5.1, one commenter agreed with the recommendation to mandate four hours of continuing education to include three hours of American Heart Association (AHA)-approved BLS training, as well as one hour of opioid continuing education. The commenter, however, recommended removing the mandated courses in ethics,

pharmacology, and infection control because these courses are burdensome and redundant, as dentists are required to have these in their practices.

RESPONSE: The Board believes that it is necessary to stay abreast of developments in ethics, pharmacology, and infection control. (See also, the Responses to Comments 18 and 19, and 20, 21, and 22)

24. COMMENT: One commenter expressed concerns regarding the proposed change to the final sentence of existing N.J.A.C. 13:30-5.1(e) as new paragraph (e)4, stating that the Board shall not accept for continuing education credit subjects in estate planning, financial or investment/tax planning, or personal health. The commenter stated that many dentists in New Jersey are small business owners and that running a dental business presents many challenges, especially financial in nature. The commenter believes that these courses help dentists to better their business model and improvements within the business model help the practice to provide better accommodation for and ultimately better care to New Jersey's public. The commenter recommended that, instead of eliminating continuing education credit for these courses the Board limit to two hours the amount of continuing education one can submit in these categories.

In addition, with respect to "personal health" continuing education credits, the commenter noted that it was not long ago that dentists had the highest suicide rate of any profession and, therefore, the commenter believes that it is discouraging and disheartening not to allow continuing education in personal health when considering the many mental health and substance abuse issues faced as a society. The commenter believes that dentists' capacity to treat the needs of the public safely, efficiently, and effectively is contingent upon our ability to maintain their own personal health and well-being. The commenter believes that allowing continuing education credits to support personal health and well-being is something important to the dental community and should be accommodated. The commenter recommended limiting to two hours the amount of continuing education allowed for "personal health."

25. COMMENT: One commenter objected to the removal of continuing education credit subjects in estate planning, financial or investment/tax planning, or personal health for credit. The commenter contended that the removal of such critical subjects is unnecessary and unhealthy. The commenter believes that it is critical for the overall well-being of dentists to allow for courses in strengthening business and maintaining personal physical and mental health. The commenter stated that a strong business and a healthy dentist allows for

increased access to quality pediatric dentistry, improves public safety, and quality dentistry for New Jersey residents.

26. COMMENT: One commenter recommended that courses on personal health be acceptable for continuing education. The commenter stated that health courses teach dentists how to counsel their patients in all aspects of their personal health, thus helping the public. The commenter also stated that it is in the public interest that dentists and surgeons be in good physical and mental health to perform quality care, and be empathetic and compassionate to patients. The commenter believes that by teaching dentists to care for themselves and others, it protects the public.

27. COMMENT: To assist in, and recognize the importance of, the promotion of work life and personal health balance, one commenter urged the Board recognize that continuing education courses in personal health, not to exceed three hours, be eligible for credit in each biennial period.

RESPONSE TO COMMENTS 24, 25, 26, AND 27: The purpose of continuing education is to enhance ever-evolving skills, both didactic and clinical skills. Although other education is commendable and an individual choice, the Board does not believe the subjects of estate planning, financial or investment/tax planning, or personal heath are related to patient safety, well-being, or access to care.

28. COMMENT: One commenter stated that, in this age of long-distance remote surgeries, and the digital shrinking of the medical world, it seems that remote CPR refresher courses would be appropriate. The commenter noted that for an initial CPR certification having instructor feedback is important. The commenter stated that the value of the annual refresher courses is the reminder of, or in the education of new guidelines (that is, breath-to-compression ratios, to do, or not do, a blind sweep, etc.) and in new CPR advents (such as when compression-only CPR became an option). The commenter believes that there is no reason that this education cannot be done digitally and/or remotely.

RESPONSE: The Board believes that the hands-on practice of the actual skills is important for maintaining proficiency and effectiveness with the procedure and, therefore, the CPR refresher course must be taken live and in-person.

29. COMMENT: One commenter recommended that each of the mandated 10 hours of specific continuing education courses at N.J.A.C. 13:30-5.1 be required to be completed in a live and in- person educational setting. The commenter believes that the continuing education on pharmacology, internal medicine, infection control, ethics, and opioid training are just as important as the CPR training and, therefore, should be

completed in a live and in-person traditional lecture format rather than a webinar format.

The commenter was concerned about the webinar format for these courses because webinars are often sponsored by large corporations and the lectures are often biased to the products or services that the corporation offers to the dentist population. The commenter also stated that many webinars are administered by entrepreneurial operations that receive sponsorships from corporations that have a vested interest in promoting products and selling attendees' personal information, and believes that these webinars are of "poor quality." In addition, the commenter stated that webinars do not offer the opportunity for experiential learning that a group can achieve by being in one place, nor are the participants aware of the size of the audience or who is participating in the webinar. The commenter further stated that, although webinars attempt to add interactivity by polling the audience about key issues, many users find the online graphs and poll results are a poor substitute for an in-room speaker asking for a show of hands. In addition, the commenter contended that webinar instructors are not able to gauge the level of understanding among the participants because of the lack of facial expressions and participants lose interest in the subject matter. The commenter further stated that communication in webinars is very structured and the participants are not able to talk with one another to brainstorm or share thoughts. The commenter believes that there is a level of synergy that can be found within a group interacting and sharing in-person that is lost over the phone or online.

The commenter stated that a live presenter engages the audience and helps drive home the message. The commenter also believes that a live in-person seminar can be dynamic, interactive experience, and affords dentists the opportunity to form valuable new relationships, which is critical for mental and physical health.

The commenter believes that CPR, pharmacology, internal medicine, infection control, ethics, and opioid prescribing training are vital disciplines that dentists need to be expert in for the protection of the public. The commenter, therefore, believes that these topics should be delivered in a traditional live in-person lecture format using the standard [page=624] continuing education protocol for mandatory Board-approved programs, and presented in a serious and formal setting rather than an impersonal and informal webinar.

In addition, the commenter stated that the recording of the dentist's attendance in these live, in-person courses would be regulated in a professional fashion because participants would complete a course completion form, which would include a post-educational activity course

evaluation form, and receive a letter of completed credit hours for their records. The commenter believes that this method would relieve the Board of the time-consuming task of reviewing the inundation of webinar sponsors applying for approval for their webinars.

30. COMMENT: One commenter recommended that the 10 hours of required continuing education of CPR, pharmacology and internal medicine, infection control, jurisprudence, and opioid pain management and alternatives should be discussed in a live, in-person, interactive setting and should not be permitted on webinars or other electronic media courses.

RESPONSE TO COMMENTS 29 AND 30: Except for the required CPR training, the Board declines to mandate a specific format for the other required continuing education courses in pharmacology and internal medicine, infection control, ethics, and opioid training. The Board agrees that these are important topics and believes the continuing education requirement can be satisfied didactically either in-person or through distance learning.

31. COMMENT: One commenter contended that proposed N.J.A.C. 13:30-5.1(e)1i, which specifies that "webinars are not considered electronic media distance learning courses provided they are live and synchronous" is too limited. The commenter believes that all webinars should be exempt from status of electronic media whether viewed in real time or previously recorded because, as technology has evolved, a webinar is just as effective, if not more effective, than attending a live "in-person" lecture. In addition, the commenter contended that a live webinar offers no advantage over a recorded webinar because a recording includes all questions posed by live viewers and their responses by the speaker, which in most cases are opened up only at the completion of the webinar presentation. The commenter also stated that, if clarification of a topic is necessary, an attendee can email the speaker similar to a person walking up after the lecture has ended and conversing with the speaker one-on-one. The commenter further stated that attending a recording is both convenient and more advantageous to dentists because you can pause and resume, and even rewind and review the recording if you missed a point. The commenter believes, therefore, that a recording becomes more valuable than attending a "live" webinar or even a "live lecture" at a conference or meeting. The commenter recommended that the Board amend the provision such that "webinars are not considered electronic media distance learning courses" to include both "live and synchronous," as well as previously recorded webinars.

RESPONSE: The Board declines to change N.J.A.C. 13:30-5.1(i)1iv as the commenter suggested and notes that it recognizes up to 20 hours of continuing education credit for any form of written or electronic media

distance learning courses, as long as the course includes a written post-test. Webinars that are live and synchronous would not be subject to this 20-hour limitation.

32. COMMENT: One commenter agreed that all licensed dental hygienists and registered dental assistants should be BLS certified, including training of an automatic external defibrillator (AED), as a matter of patient safety, especially when working under general supervision.

The commenter, however, expressed concerns with the proposed amendments to N.J.A.C. 13:30-5.2 and 5.3, concerning continuing education requirements for licensed dental hygienists and registered dental assistants and limited registered dental assistants in orthodontics, respectively. The commenter contended that the continuing education requirements for preventing and controlling infectious disease, professional ethics, and education on opioids are cumbersome and redundant to dental hygienists and registered dental assistants' baseline training.

The commenter stated that the continuing education requirement for infection control is redundant because dental hygienists and registered dental assistants must already be up-to-date on proper OSHA standards. The commenter stated that, in accordance with the ADA policy regarding mandatory OSHA training, it is currently the responsibility of the dental offices/owners that employ dental hygienists and dental assistants to make sure they have received the most up-to-date OSHA training.

In addition, the commenter noted that dental hygienists and dental assistants must take and pass a New Jersey Jurisprudence exam before obtaining a State license and, therefore, requiring continuing education in ethics or mandating an online course in New Jersey Jurisprudence is redundant.

The commenter also believes that a requirement on opioid continuing education is unnecessary given the narrow scope of pharmacological training dental hygienists and dental assistants receive during their schooling. The commenter does not believe that requiring opioid continuing education for dental hygienists and dental assistants is going to fix or even improve the opioid epidemic, especially considering they are not DEA registrants or eligible to prescribe opioids.

RESPONSE: The Board thanks the commenter for its support to require all licensed dental hygienists and registered dental assistants to have CPR training as a condition of licensure/registration renewal.

The Board believes that the required continuing education topics at N.J.A.C. 13:30-5.2(a)1 and 5.3(f)2 are those that, at a minimum, are necessary for licensed dental hygienists and registered dental assistants and limited registered dental assistants in orthodontics to keep current about important developments in the field. The Board proposed continuing education requirements in infection control to ensure public safety. Based upon the Board's experience, the Board believes there is a need in the profession to keep current about infection control procedures beyond any Federal requirements for OSHA and CDC training. The Board also believes that it is important for all dental auxiliaries to keep abreast of ethical considerations and changes to New Jersey laws, rules, and regulations. In addition, the Board believes that continuing education in prescription opioid drugs is important for overall patient care and awareness of patient health because the education relates to the signs of addiction, addiction patterns, and drug seeking behavior. Accordingly, the Board has determined that dental hygienists and dental assistants must also take at least one credit of continuing education in educational programs or topics concerning prescription opioid drugs.

33. COMMENT: One commenter expressed concern with the limitations in defining "eligible persons" at proposed N.J.A.C. 13:30-5.1(n). The commenter stated that, as proposed, it is limited to a person under 19 already with a NJ Family Care coverage; a child under the care of the Department of Children and Families, or an adult with coverage or enrollment in "the Medicaid program established pursuant to P.L. 1968, c. 413 (N.J.S.A. 30:4D-1 et seq.), the Pharmaceutical Assistance to the Aged and Disabled program established pursuant to P.L. 1975, c. 194 (N.J.S.A. 30:4D-20 et seq.), or the Senior Gold Prescription Discount Program established pursuant to P.L. 2001, c. 96 (N.J.S.A. 30:4D-43 et seq.)." The commenter contended that, as the Board notes in its Social Impact statement, because there is a benefit to society by encouraging licensees and registrants to provide dental care to those who otherwise may not be able to have access to it, "eligible persons" should be expanded to include the uninsured, as well as those insured with limited coverage, and hence otherwise large and unmanageable out-of-pocket expenses, for they also have limited access to care. The commenter believes that by including the uninsured, veterans, first responders, and those affected by financial hardship, the social impact will be significantly improved.

RESPONSE: As the commenter notes, the Board agrees that there is societal benefit to encouraging licensed dentists, licensed dental hygienists, and registered dental assistants to provide dental care to those who otherwise may not be able to have access to it. The Board's

proposed definition of "eligible person" mirrors that of the statutory definition at N.J.S.A. 45:6 10.4.

Sedation

34. COMMENT: Several commenters expressed support for the Board's proposed N.J.A.C. 13:30-6.2(s), which provides that a dentist advertising sedation services who uses the terms "sleep," "sleep dentistry," "sleeplike-state," or any similar words or combinations in connection with the provision of dental services are considered to be inducing deep sedation and must comply with the requirements at N.J.A.C. 13:30-8.3. The commenters believe that any dentist advertising [page=625] "sleep dentistry" or any other similar words or combinations deemed to be providing general anesthesia and be required to hold a General Anesthesia Permit. The commenters stated that words such as "sleep dentistry" minimize the gravity of general anesthesia and the necessary training required to perform these services.

RESPONSE: The Board thanks the commenters for their support.

35. COMMENT: One commenter stated that the proposed updates to the review of medical records, anesthetic records, and equipment and drugs promotes overall safety and ideal patient-selection for in-office sedation and is favorable for all providers of sedation. The commenter stated that patient selection is a primary focus of determining whether the patient is a candidate for in-office sedation and to make this determination, a personalized assessment must be conducted because it includes an in-depth review of the patient's medical history, records, and treatment plan. The American Society of Dentist Anesthesiologists (ASDA), in accord, explains:

> “Anesthesia and surgery affect the entire body, it is important for the anesthesia care provider to be able to anticipate the [affects] effects of all anesthetics in relation to the drugs and medications that the patient is taking and may have been used in the recent past. This includes all prescription or nonprescription drugs; over the counter, herbals, or ‘street drugs’. Even marijuana, alcohol and tobacco use affects the way anesthetic drugs work in the body. Many patients may have chronic medical conditions, such as diabetes, renal failure, heart or lung problems that can make routine dental work challenging in the conventional dental office setting. These conditions necessitate careful monitoring of vital signs during the procedure. Additionally, anesthesia may be provided to control pain, anxiety and delirious physiological responses, such as elevated blood pressure and heart rate that accompany them. http://www.asdahq.org”

The commenter believes that the proposed change is paramount for patient safety.

RESPONSE: The Board thanks the commenter for its support.

36. COMMENT: One commenter recommended that the Board amend proposed N.J.A.C. 13:30-8.2(d) to include specific training requirements of 20 live patient case experiences. The commenter noted that the ADA guidelines require 60 hours of instruction and 20 live case experiences, a requirement it has fought to maintain for those dentists who wish to practice intravenous sedation.

RESPONSE: In accordance with existing N.J.A.C. 13:30-8.2(d) supervised clinical training includes managing patient care for 20 PCS patients.

37. COMMENT: One commenter requested that the Board distinguish between minimal and moderate sedation. The commenter stated that the American Academy of Pediatrics/American Academy of Pediatric Dentists (AAP/AAPD) and ADA differentiate between the two, and the practitioner must be prepared for both situations. *See* AAPD/AAP definitions, Pediatrics, Volume 138 number 1, p. e9-e10 (July 2016). The commenter contended that defining the level of sedation, the category of medications (that is, propofol should not be used for mild or moderate sedation), prohibiting multidrug cocktails (that is, fentanyl and propofol) and guidelines specific for children as opposed to adults (specifically certification in Pediatric Advanced Life Support (PALS)) will create a safer environment for the public.

RESPONSE: The Board's rules, at N.J.A.C. 13:30-8.2 (PCS/moderate) and 8.4 (enteral sedation/minimal), make the distinctions the commenter suggested. Although the Board agrees that propofol should not be used for mild or moderate sedation, the Board's rules do not specify the specific agents that may be used when administering sedation. The Board believes each dentist should follow the standard of care. The Board agrees with the commenter that guidelines for the administration of sedation in children is important and this topic will be considered for a future rulemaking, if deemed necessary.

38. COMMENT: Several commenters expressed support for the Board's requirement that all dentists holding an enteral, PCS, or general anesthesia permit should be trained in Advanced Cardiac Life Support (ACLS) and noted that this is currently a requirement of the American Association of Oral and Maxillofacial Surgeons. The commenters, however, disagreed that all personnel who are present and trained to assist in the monitoring of a patient whenever PCS, enteral sedation, or general anesthesia is employed must be trained in ACLS. The commenters stated that this requirement is unnecessary and impractical.

The commenters noted that dental assistants are educationally unqualified to pass the course and not credentialed to start intravenous lines, push medications, or intubate patients, which are all duties required of those trained in ACLS. The commenters believe that BLS should be the only requirement.

One of the commenters also noted that office staff can be performing BLS and defibrillation while the code is being run by an ACLS-trained dentist. This commenter also noted that the two days of training for staff would be burdensome on small businesses.

One commenter stated that that a modified CPR/BLS course integrated with additional emergency training would be far more valuable for dental office personnel.

39. COMMENT: A few commenters questioned requiring ACLS certification for dental assistants involved in the care of patients undergoing sedation. Although the commenters agreed with the concept of holding these assistants to a higher standard so they are able to help recognize and manage emergencies that may arise, they noted that most emergencies stemming from sedation are respiratory, not cardiac. The commenters stated that, while ACLS does cover some of this material, the main thrust is dysrhythmia management and the primary focus is high quality CPR, just as taught in BLS. The commenters believe that advanced interventions like cardioversion and defibrillation should be understood by the team leader, that is, the dentist, but defibrillation becomes automated when the office has an AED. One of the commenters does not believe that ACLS certification should be used as a licensure requirement or as a statement of competency.

The commenters noted that short programs like BLS, ACLS, and PALS are designed to have a wide spectrum of healthcare providers acquire basic, uniform approaches that may lead to improved teamwork and better outcomes in life-threatening medical crises. The commenters believe, however, that a dental assistant or even a dentist with ACLS certification will not respond to such an emergency as effectively as an ACLS-certified EMT, emergency medicine physician, or cardiologist.

Although the commenters believe that dentists using sedation in any form should successfully complete ACLS and maintain that continuously, they believe that a different approach makes more sense for assistants. The commenters recommended mandating training for dental assistants who work in sedation/General Anesthesia offices that are specifically designed to address the enhanced role of such assistants in patient monitoring, airway management, and emergency recognition, and response. The commenters stated that successful completion of ACLS may be of some benefit, but patient safety would be better served by having dental

assistants trained in managing sedated patients and helping to handle over-sedation, laryngospasm, allergic reactions, and other sedation-related events in the dental/oral and maxillofacial surgery context. The commenters also stated that hands-on simulation training may be of particular value along with didactics.

One of the commenters noted that the ASDA guideline for the use of sedation and general anesthesia by dentists differentiates the level of sedation and respective requirements. The commenter stated that it is only for deep sedation and general anesthesia that the ASDA outlines requirements for personnel wherein it states "administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentists and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider."

40. COMMENT: One commenter urged the Board to retain the current PCS and general anesthesia rule and refrain from adopting the proposed requirement of BLS and ACLS for auxiliary personnel. The commenter contended that, if adopted, the requirement will have an adverse impact on access to and timely receipt of care while simultaneously substantially driving up costs without achieving any appreciable safety benefits.

The commenter stated that ACLS training is not only intense, expensive, and beyond the ability of many dental assisting personnel but involves instruction not needed when PCS, general anesthesia, or enteral conscious sedation is administered by a permit holder or a physician in a [page=626] dental office. The commenter contended that, if the number of dental offices at which a patient can receive PCS, general anesthesia, or enteral conscious sedation services is substantially reduced--as would, almost, certainly occur if the proposed regulation on these subjects is adopted--young children, special needs patients, and underserved populations will be especially and disproportionately severely negatively impacted. The commenter stated that their only alternative will be to receive treatment in a hospital operating room where costs are substantially higher, waiting times for treatment are substantially longer, and anxiety levels are appreciably greater. At a time when alternatives to higher priced and equally or more effective care are being sought, this proposal would have exactly the opposite effect by unnecessarily driving people to hospitals.

RESPONSE TO COMMENTS 38, 39, AND 40: The Board agrees with the commenters that those assisting in the monitoring of a patient do not need to have both BLS and ACLS, or their equivalent, training. Instead,

the Board intended to allow these individuals to have the option of maintaining current certification in BLS or ACLS training. Accordingly, upon adoption, the Board will change N.J.A.C. 13:30-8.2(h), 8.3(p), and 8.4(j) to change "and" to "or." Additional public notice of this change is not necessary because the amendment does not alter existing practice or impose any additional burdens.

41. COMMENT: One commenter recommended that, with respect to the required inspections at any facility administering PCS, or for mobile equipment, drugs, and supplies, that the Board specify who would be responsible for completing the inspections. The commenter believes that it would be appropriate for the inspector to have a background specifically in dental anesthesia; for example, someone in the dental community, such as an oral surgeon who administers PCS or a dental anesthesiologist.

42. COMMENT: Several commenters noted that the New Jersey Society of Oral and Maxillofacial Surgeons (NJSOMS) provides the office inspections for general anesthesia permit holders and believe that NJSOMS should be approved to provide the additional inspections for the remaining permit holders.

RESPONSE TO COMMENTS 41 AND 42: The Board designates persons who have experience in providing PCS/moderate sedation, deep sedation, and general anesthesia services.

43. COMMENT: Several commenters recommended eliminating a mobile anesthesia permit for any level of anesthesia. The commenters stated that each anesthesia provider should be required to hold a permit for each office that anesthesia is provided and be subject to the appropriate requirements for facilities, medications, and inspections.

RESPONSE: The Board notes that it does not require a mobile anesthesia permit. Instead, the Board's rules impose requirements upon permit holders who use mobile equipment, drugs, and supplies for the administration of PCS, general anesthesia, or enteral sedation.

44. COMMENT: One commenter stated that the proposed change to increase inspection years from six years to three years is aggressive and does not provide more accurate information regarding the inspection process. The commenter questioned, for example, who will be performing these inspections and what is a reasonable time frame in which the inspections will be held. The commenter believes that the goal should be to not limit practice or patient care in favor of policies.

45. COMMENT: One commenter disagreed with the Board's proposed change of the interval of office inspection from six years to three years because of the economic impact of this requirement, lack of manpower to

complete these inspections, and questionable safety implications of this change. The commenter believes that the Board should use the model of the American Association of Maxillofacial Surgeons (AAOMS), which requires rigorous inspection of oral and maxillofacial surgical practices for anesthesia safety every five years. The commenter contended that deviating from this accepted interval would incur increased cost without proven benefit.

46. COMMENT: One commenter stated that the proposed three-year inspection would not be efficacious in improving the risk/cost ratio.

47. COMMENT: One commenter stated that the required office inspection period for general anesthesia permit holders is currently six years. The commenter noted that AAOMS requires their members to have office inspections every five years. The commenter contended that more frequent inspections would not improve outcomes and would be a burden on the existing inspectors. The commenter suggested that, if the State wanted closer monitoring of offices, the Board should require permit holders to submit an attestation that they are in compliance during each biennial licensure renewal.

RESPONSE TO COMMENTS 44, 45, 46, AND 47: In accordance with the Board's existing rules at N.J.A.C. 13:30-8.2(j) and 8.4(p), there is a three-year inspection period for mobile equipment, drugs, and supplies for both PCS and enteral sedation. The Board believes that the inspection period for mobile equipment, drugs, and supplies for each level of sedation, including general anesthesia should be standardized at three years. In addition, the Board believes that, to ensure patient health, safety, and welfare, it is reasonable to require equipment and drugs that are transported between facilities or used intermittently, potentially, by various providers to be inspected more often than offices. The Board is not aware of any resource issues that would impact conducting the required inspections of all permit holders. The Board notes that, although it currently requires certifications as part of the biennial permit renewal process, periodic inspections are necessary to ensure public safety.

48. COMMENT: One commenter stated that it is concerned with the proposed amendments to the rules for sedation and the potential impact on access to care. The commenter acknowledged the value of patient safety, which is imperative, and believes there must be a balance between maintaining the highest levels of patient safety and addressing concerns regarding access to care. The commenter contended that access to care will be diminished if practitioners are faced with far reaching rule requirements. The commenter stated that, if there is a reduced number of providers offering in-office sedation, patients will be forced to choose between not receiving care or seeking the alternative,

such as a surgery center or hospital for general anesthesia, which may not be a financial option for many patients or may result in increased wait times for treatment. The commenter stated that, although many of the changes are aimed at increasing patient safety, some of these rules are unnecessary and will not lead to any actual improvement in patient safety. The commenter believes that the ramifications of the rule proposal that are over-reaching should be extensively examined from an access to care standpoint.

RESPONSE: The Board believes that its rules and the proposed amendments ensure patient safety and does not anticipate any changes to the number of providers. The Board also notes that upon adoption, it is changing some of its proposed requirements, such as requiring both BLS and ACLS for those assisting with the monitoring of sedation to clarify that only one is required for those assistants, which will reduce any impact its rules and amendments may have. (See the Response to Comments 38, 39, and 40)

49. COMMENT: Several commenters stated their support to have appropriate facilities, equipment, medications, and training necessary to rescue a patient. The commenters noted that there is a fine line between minimal, moderate, and deep sedation and that those providing anesthesia must be able to recognize the levels of anesthesia and be able to respond appropriately. The commenters, however, expressed concern with the requirement that all medication kits contain dantrolene.

The commenters noted that dantrolene is a drug used to treat and prevent malignant hyperthermia, a condition most often associated with the use of volatile anesthetic gasses, such as halothane, sevoflurane, desflurane, isoflurane, or enflurane. The commenters believe that it is unnecessary and unduly burdensome to require dantrolene for all offices because it is expensive, has a short half-life, and requires special preparation. The commenters recommended that only those offices that use volatile anesthetic gases be required to have dantrolene, which is consistent with the Board's existing regulations.

50. COMMENT: A few commenters stated that the addition of dantrolene to the list of medications required in all offices practicing any form of sedation is difficult to justify and may actually be counterproductive. The commenters stated that malignant hyperthermia (MH), is a rare and serious complication of general anesthesia, with an incidence of about 1/30,000 pediatric and 1/100,000 adult general anesthetics, but does not occur unless an MH-trigger agent is used. The commenters noted that the Society for Ambulatory Anesthesia does not mandate the availability of dantrolene when patients are not exposed to MH-triggering agents. The commenters also noted that the Malignant

Hyperthermia Association of the United States (MHAUS) only [page=627] recommends dantrolene in offices where patients are exposed to MH-trigger agents.

The commenters stated that there is debate in the medical anesthesiology community as to whether dantrolene (or a comparable agent) should be available in facilities that do not expose patients to volatile anesthetics when the only potential exposure might be the highly unlikely need to use succinylcholine for airway rescue. The commenters also stated that for dental facilities where enteral sedation is being done, there are no triggering agents used and far more importantly, the dentist is unlikely to be adequately trained or equipped to use succinylcholine for airway rescue. The commenters stated that, in the highly unlikely event that succinylcholine is used and produces an even more unlikely sequela, that is, an MH crisis, that facility and that clinician will not be able to resuscitate the patient successfully with or without dantrolene. The commenters also stated that that incredibly rare event is so catastrophic, that a dentist with enteral sedation training can, at best, be expected to do basic life support and possibly keep the patient alive until he or she can get to a higher level of care. The commenters stated that the same is true of dentists with parenteral, moderate sedation training, although their capabilities might be somewhat enhanced by ongoing experience obtaining IV access. In addition, the commenters stated that, even in an oral and maxillofacial surgeon's office where deep sedation is done, a positive outcome for this incredibly unusual event would require well-rehearsed actions done properly and efficiently by the entire team. The commenters noted that MH crisis management is a difficult and demanding team effort even in a major medical center with the optimal facilities, manpower, training, and preparation. The commenters recommended that the Board amend the rule as follows:

> xx. Dantrolene (or a comparable drug) must be available to any office where patients may be exposed to MH triggering agents. In addition, these facilities must have equipment, supplies and training to manage an MH crisis.

The commenters contended that this suggested language makes clear to all clinicians who do expose their patients to MH-triggering agents that the Board is holding them to a patient safety standard that is not merely access to a drug, but the capability to respond meaningfully to this unusual catastrophic event. The commenters stated that there is far more to do during an MH crisis than just opening multiple vials of dantrolene and making them ready for administration, including ventilation/oxygenation, aggressive cooling, fluid administration, dysrhythmia management, and more.

The commenters believe that the suggested language would also give sedation and general anesthesia providers who do not use any MH-triggering agents the opportunity to select a paralytic agent other than succinylcholine (one that is not an MH trigger) as their airway rescue drug (N.J.A.C. 13:30-8.2(i)1vii). The commenters noted, that in well over a hundred years of cumulative experience they have had a total of zero laryngospasms that actually required the use of succinylcholine. Nonetheless, following the lead of MHAUS and SAMBA (Society for Ambulatory Anesthesia), even the potential exposure of a patient to succinylcholine, a questionable but possible MH trigger in the absence of volatile anesthetics, suggests the need for readiness for an MH response. In the view of the commenters, readiness must not be defined merely by access to a drug, but by the existence of a plan to manage MH and the ability and preparedness to actually execute that plan.

RESPONSE TO COMMENTS 49 AND 50: The Board agrees with the commenters that dantrolene is not needed at each practice location at which sedation is administered and should only be required in those locations where patients are exposed to MH-trigger agents. The Board, upon adoption, will change N.J.A.C. 13:30-8.2(i)1xx and 8.3(f)1xx to add language that dantrolene is required in each practice location at which succinylcholine is used routinely but not for emergency use or at which halogenated hydrocarbon general anesthetic inhalation agents are used. In addition, the Board proposes to change N.J.A.C. 13:30-8.4(k)6xx, which pertains to dentists with an enteral sedation permit, to remove dantrolene from the emergency drug kit because MH triggering agents are not used in the provision of enteral sedation. Additional public notice of this change is not necessary because it lessens the burden on the regulated community and does not diminish patient health, safety, and welfare.

51. COMMENT: One commenter suggested that the list of medication categories should be more consistent with what is needed for PCS. The commenter stated, for example, that cardio drugs and dantrolene are excessive for PCS.

RESPONSE: When providing PCS/moderate sedation, there is a risk of the patient reaching a deeper level of sedation than intended. Accordingly, the Board believes that each of the drugs, except for dantrolene, that are proposed for the emergency drug kit are necessary to address reasonably foreseeable complications. As discussed in the Response to Comments 49 and 50, upon adoption the Board will limit the requirement for dantrolene to be in the emergency drug kit for only those dental practice locations at which succinylcholine is used routinely, but not for emergency use or at which halogenated hydrocarbon general anesthetic inhalation agents are used.

52. COMMENT: One commenter disagreed with the Board's proposed emergency kit. The commenter stated that laryngoscopes, assorted size blades, endotracheal tubes (ET), and magil forceps should not be included in this list. The commenter also stated that ET intubation is a difficult procedure for anesthesiologists on a stable sedated patient, let alone one in an emergent setting. The commenter also stated that dentists have little to no training in the placement of ET tubes and it would take dozens of intubations on patients to feel comfortable placing ET tubes. The commenter believes that if there was an emergency and a dentist tried to place a tube they could cause more harm than good and dentists should not do harm. The commenter recommended requiring adult and pediatric size laryngeal mask airway (LMA) because this is an acceptable advanced airway that provides an exceptional seal in the oropharynx and is very difficult to harm a patient.

53. COMMENT: One commenter recommended that the Board remove the requirement for laryngoscopes and endotracheal tubes and, instead, to require LMA, which serves the same purpose. The commenter stated it is safer and easier to operate for a dentist to not intubate regularly. The commenter also stated that intubations and the use of laryngoscopes require a high skill level that needs regular use to be effectively maintained. The commenter, moreover, stated that unsuccessful attempts to use the laryngoscope can put the patient at risk and believes that requiring it in every office would encourage use by practitioners who might not be confident enough in the equipment to use it safely.

54. COMMENT: One commenter recommended that the Board abandon the proposed rule change of requiring Parenteral Conscious Sedation (PCS) providers to maintain ET for placement of an advanced airway. The commenter also recommended modifying the provision to state that any PCS provider have a fully functional Ambu bag to administer positive pressure oxygen in the event of a medical emergency and the appropriately sized LMA or other oral airway devices in their offices for emergency use. The commenter believes that many dental professionals who are PCS providers will be better suited placing an LMA in a medical emergency instead of attempting to intubate a patient in respiratory distress/failure. The commenter stated that, during a rescue, intubation with an ET takes much skill and training to perform safely and properly in any given situation, let alone a high stress situation like a true respiratory emergency. The commenter also stated that most dental providers performing PCS would be better suited using an advanced airway like an LMA. The commenter believes that it would be a safer alternative for the patient that an LMA or oral airway with Ambu bag be utilized in this situation.

55. COMMENT: One commenter recommended that the Board abandon the proposed rule change of requiring Parenteral Conscious Sedation (PCS) permit holders with having ACLS or PALS. The commenter stated that BLS is appropriate training for the safety of patients being treated with PCS. The commenter also stated that it is unnecessary for PCS providers to maintain ET for placement of an advanced airway. The commenter recommended that the Board modify this provision to state that any PCS provider have a fully functional Ambu bag to administer positive pressure oxygen in the event of a medical emergency and the appropriately sized LMA devices in their offices for emergency use.

RESPONSE TO COMMENTS 52, 53, 54, AND 55: ACLS training is necessary for all dentists who administer PCS, use general anesthesia, or use enteral sedation because patients may fall into a deeper level of [page=628] sedation than intended as the line between sedations levels is thin. The Board, therefore, declines to remove the requirement for PCS permit holders to have ACLS training, or its equivalent. In addition, the Board declines to eliminate the requirement that an emergency kit include laryngoscopes, assorted size blades, ET tubes, and magil forceps. ACLS trains dentists to perform ET intubation; therefore, this equipment may be necessary for patient safety in emergency circumstances. Dentists are professionals who are expected to assess their patient, and determine and implement the appropriate rescue measures. Nothing in the Board's rules precludes a dentist from having an LMA available and using it, as appropriate.

56. COMMENT: To reduce emergencies, one commenter recommended that the Board require anyone performing any form of pharmacology induced sedation (other than simple nitrous oxide/oxygen) and deep sedation and general anesthesia to use capnography.

RESPONSE: The Board agrees that capnography is important for monitoring ventilation as it is the most sensitive measurement of exhaled carbon dioxide. As proposed in this rulemaking, dentists with a PCS permit must be competent in the use of capnography and have a capnometer in its facility. In addition, as proposed, dentists with a general anesthesia permit must also have a capnometer. Although the Board agrees that a capnometer is an important piece of equipment and recommends its usage when enteral sedation is administered, the Board declines to mandate its usage.

57. COMMENT: One commenter recommended amending proposed N.J.A.C. 13:30-8.2(d)7 to eliminate requiring certification in capnography because the use of precordial/pretracheal stethoscope is just as accurate. The commenter stated that it has opposed the 2016 ADA Guidelines that mandated capnography and supported the AAP/AAPD guideline/position that dentists should have a choice of capnography or

precordial/pretracheal stethoscope to monitor breathing during PCS. The commenter also stated that AAP/AAPD guidelines do not require preclusions or invalidations to apply for a dentist to select stethoscope instead of capnography. The commenter recommended providing the practitioner with the choice between capnography and the use of a precordial/pretracheal stethoscope.

RESPONSE: The Board declines to substitute competency using a precordial/pretracheal stethoscope instead of capnography as proposed at N.J.A.C. 13:30-8.2(d)7. Although using a stethoscope allows a dentist to hear breath sounds and heart rhythms, which are important observations, it does not provide the same level of necessary information concerning carbon dioxide output that a capnometer does. The monitoring of end-tidal carbon dioxide is critical for monitoring the patient's response to effects of sedation and for assessing and treating a patient in respiratory distress.

58. COMMENT: One commenter requested clarification about the proposed amendment, which would require a separate general anesthesia permit per location where general anesthesia is administered. The commenter stated that the rule language does not differentiate providers for which this would be required. The commenter contended that, in instances where an M.D. or D.O. is administering anesthesia services, it is appropriate for a separate anesthesia permit to be required because their equipment/drugs/supplies have not been through a thorough inspection by the Board. The commenter also contended, however, for mobile providers, such as dentist anesthesiologists and oral surgeons, who have successfully completed a comprehensive inspection, as required by the Board, an additional permit appears redundant. In addition, the commenter averred that adding this requirement for mobile providers creates hardship for providing services in a timely or emergent basis due to administrative constraints that are already met.

RESPONSE: The Board notes that the amendments at N.J.A.C. 13:30-8.3(c) codify the Board's existing practice with respect to branch locations by specifying that a separate general anesthesia permit is required for each practice location at which it is administered, and that each permit must be renewed biennially. Dentists providing itinerant anesthesia services must now have their equipment inspected and approved by the Board, or its designee, at least once every three years. The Board acknowledges that there are additional issues and questions concerning the delivery of services by itinerant dentists and will address them in a future rulemaking.

59. COMMENT: One commenter recommended that the Board amend proposed new N.J.A.C. 13:30-8.3(j), which sets forth the facility standards for offices in which general anesthesia is administered to state that

(addition in bold) "the facility standards for offices in which general anesthesia is **regularly** administered are the same as those proposed for offices conducting PCS, as described above. In addition, the offices must have the equipment and supplies required by the Board at subsection (f) and at N.J.A.C. 13:30-8.26, which must be readily accessible and maintained in good operating condition."

RESPONSE: The Board believes that for patient safety, regardless of the frequency in which anesthesia services are administered, all offices must meet the standards set forth at N.J.A.C. 13:30-8.3(j). The Board declines to change the rule as the commenter suggested.

60. COMMENT: One commenter stressed the importance of clarity with regards to provider type for anesthesia services. The commenter noted that dentist anesthesiologists are trained through a rigorous program requiring a minimum of 24 months in a hospital setting, providing the skills necessary to be proficient in providing all levels of anesthesia services for ambulatory patients undergoing a variety of dental procedures. The commenter also noted that dentist anesthesiologists have the highest level of training and comprehension of anesthesia guidelines within the field of dentistry; their training includes responsibilities to meet the same competencies as medical anesthesiologists.

RESPONSE: The Board agrees that training is important and notes that its rules recognize differing levels of sedation and specify the training necessary to provide those sedation services. The Board grants sedation permits on the basis of the level of anesthesia services provided. A dentist holding a general anesthesia permit may provide all three levels of sedation services.

61. COMMENT: One commenter thanked the Board for its continued interest in the provision of safe anesthesia services for patients in the State. The commenter believes that the Board should review the American Society of Dental Anesthesiologists: Parameters of Care as published in Anesthesia Progress, 31 Dec. 2017. The commenter believes that these parameters represent a considered opinion and may reflect the current wisdom in this area of practice.

RESPONSE: The Board thanks the commenter for its suggestion and notes that it reviewed these parameters as part of this rulemaking.

62. COMMENT: One commenter expressed concerns with the facility/suction back-up requirements. The commenter stated that, although the Board's proposal makes sense in offices that practice IV sedation, it lacks feasibility in a general dentistry office. The commenter also stated that "battery backup" technology does not exist for something as large as a "suction" or "vacuum" system and,

therefore, an automated standby generator would need to be purchased and installed. The commenter believes that many offices would not be able to have this apparatus installed because commercial buildings, strip malls, and offices on higher floors will not allow the installation of such an apparatus, nor will a landlord allow modification on a leased site. The commenter also noted that local and State zoning fire code laws will also interfere with the installation of such systems. The commenter contended that the Board is requiring equipment that cannot be accomplished. The commenter stated that the cost of an automated generator system will exceed $ 20,000 per site.

RESPONSE: The Board notes that it does not require offices to have an automated generator system nor battery back-up for suction or vacuum system. N.J.A.C. 13:30-8.26 requires each dental office, facility, dental clinic, or institution at which there is patient contact to have back-up, battery-operated equipment consisting of, at a minimum, lighting, a blood pressure monitoring device, and a pulse oximeter, which shall be readily accessible and properly operating.

63. COMMENT: One commenter recommended that the Board amend proposed N.J.A.C. 13:30-8.26 to eliminate the requirement for battery back-up suction and pulse oximeter. The commenter believes that this equipment is excessive for anyone other than those administering PCS. The commenter recommends amending the proposed rule to make it a suggestion for the general dentist and required equipment only for those with a PCS permit.

RESPONSE: The Board declines to eliminate the requirement for back-up, battery-operated pulse oximeter for all dental offices, facilities, clinics, or institutions at which there is patient contact. The Board believes that this requirement is reasonable and essential to ensure patient health, [page=629] safety, and welfare. In addition, the Board notes that there is no requirement for a back-up, battery-operated suction.

64. COMMENT: One commenter expressed concerns with the requirement that each dental office, facility, dental clinic, or institution at which there is patient contact to have an AED. The commenter stated that an AED is excessive and expensive, and in the hands of general dentists not familiar with its use may not be the best option for the patient. The commenter believes that when rescue squads are located in a close proximity to the dental office, this is a safer and more effective option than a dentist with no live experience trying to use it in a pressure situation.

RESPONSE: The Board believes that an AED is a necessary piece of equipment for dentists to meet the standard of care for ensuring

patient health and safety. The Board notes that the use of an AED is part of the BLS training required of all dentists. The Board acknowledges that there is a cost associated with obtaining an AED and believes that any costs that may be borne by members of the regulated community as a result of this requirement are outweighed by the benefit to patient health, safety, and welfare.

Infection Prevention Education

65. COMMENT: One commenter expressed concerns with proposed new N.J.A.C. 13:30-8.5A that requires all licensed dentists, at least once a biennial period, to provide, or make available, infection prevention education and training to all personnel involved in patient-related sterilization, patient care, and/or maintaining equipment. The commenter stated that because the rule language is vague, there will be compliance issues. The commenter stated that most offices provide customized and regular training for all aspects of patient care and facility utilization. The commenter also stated dentists are required to meet or exceed OSHA and sterilization standards, and this may require more, less, or customized training within the specific office. The commenter contended that this burden should continue to remain within the dentist's responsibility.

REPONSE: The Board believes that this requirement, in addition to the proposed mandatory continuing education for licensees and registrants, will ensure that all personnel involved in patient-related sterilization, patient care, and/or maintaining equipment are properly educated and trained on a regular basis, which will protect the health and welfare of patients and dental personnel.

Treatment Plans

66. COMMENT: One commenter stated that the mandate of patients signing off on treatment plans is inefficient, ineffective, and would do little in the way of patient education. The commenter contended that, instead, it would provide liability lawyers with a legal angle to pursue with any unfavorable treatment result. The commenter stated that due diligence with respect to patient education and options, such as specialist referral, are currently part of the dental treatment planning process, so the idea of a patient signing off on perio scaling or a Class 1 restoration amounts to a waste of time, and potentially leads to an uptick in lawsuits against dentists.

67. COMMENT: One commenter noted that most dental offices have policies in place regarding written/signed treatment plans and the patient is already under the protection of New Jersey Consumer Protection laws. The commenter contended that "codifying" this requirement into the Board's rules will produce an issue of double

jeopardy and needlessly increase the regulatory burden on smaller offices. The commenter noted that treatment plans are typically "fluid" and change intra-operatively; for example, restorative surfaces are changed, as are radiographs, and other such add-ons or subtractions. The commenter stated that, according to the Board's proposal, a verbal consent is no longer adequate. The commenter also stated that, although the proposal uses the term "substantial" in reference to any "changes," there is no qualification or definition as to what "substantial" entails. In addition, the commenter contended that the patient will now view the treatment plan as a "contract," which will lead to spurious Board actions against legitimate dental treatment and billing.

68. COMMENT: One commenter expressed concern with the proposed requirement to have a signature for all treatment plans. The commenter believes that such a requirement is excessive and a logistical nightmare for busy offices. The commenter noted that dentists do many small treatments that do not take a lot of time or money, and they also add/modify treatment during procedures. The commenter contended that stopping a procedure so a staff member can write another treatment plan and then have a numb patient sign it, so the procedure can continue is not in the patients' best interest. In addition, the commenter questioned what the term 'significant changes' even means. The commenter provided the examples of having a patient in for number 4 MO (menial occlusal surface) and realizing during the procedure that number 5 distal also has decay is a significant change (doubling the original treatment plan) or doing crowns on number 2, 3, and 4 and realizing there is distal decay on number 5 is a much less significant change to the treatment plan, yet the change for both is the same. The commenter stated understanding the need for a patient to understand and sign large treatment plans, but believes there should be a threshold for the need for a signed treatment plan, such as anything over $ 500.00.

69. COMMENT: One commenter stated that although it agrees that a patient should sign a treatment plan as a measure of obtaining consent and to review any financial obligations the patient would possess as a result of obtaining treatment, the commenter believes that requiring "the patient ... sign a revised treatment plan if there are any significant changes to the treatment plan," is not practical or realistic in certain situations. The commenter stated that obtaining verbal consent to a change in a pre-existing treatment plan should be acceptable in those circumstances where a newly signed treatment plan is not possible and/or could potentially compromise patient care or safety, for example when mid-treatment in a procedure or during a sedation case. The commenter contended that requiring that the patient to sign a revised treatment plan if there are any significant changes

to the existing treatment plan presents many problems. The commenter questioned what would be considered a significant change. The commenter stated that a clinical and radiographic examination can only provide so much information to the clinician and that in many instances, there can be changes in the treatment plan for a variety of reasons that cannot be anticipated by the clinician.

The commenter also noted in situations where there is a "significant" change occur during sedation, it becomes difficult to obtain the necessary written consent. The commenter stated that patients who require sedation for safe and effective treatment when clinical caries are detected often times cannot tolerate routine radiographs, without which a comprehensive and accurate treatment plan cannot be fabricated and, in those situations, before any treatment is rendered, radiographs are obtained once the patient is sedated. The commenter also stated that, after obtaining diagnostic radiographs, the original treatment plan is highly likely to change, and it is not realistic to stop a sedation procedure, or extend time under sedation to fabricate and sign a new treatment plan with the guardian or proxy. Those extra steps use valuable time that can compromise patient safety and lead to needing additional sedation visits. In both a dental office and hospital setting, signing an updated treatment plan in the middle of any sedation is completely impractical. It is important to note here that in these sedation cases informed consent is obtained and signed prior to the sedation. The consent addresses all possible treatment outcomes, just not tooth specific as may be set forth in a formal treatment plan.

The commenter, therefore, recommended that the Board consider in which situations verbal consent to a revised treatment plan would be sufficient, specifically where it would directly impact patient care and safety.

70. COMMENT: One commenter believes that treatment plans with options should be discussed and presented for all treatment to be rendered for all patients. The commenter is concerned about the definition of significant change for a revised and signed treatment plan as this can be very difficult when working with a vulnerable population, including children and special needs patients. The commenter stated that for the safety of these patients, it is critical to work quickly and efficiently to avoid unnecessary delay for patients and complete the best care possible.

71. COMMENT: One commenter requested that the Board reconsider the feasibility of the requirement for a signed treatment plan. The commenter stated that the treatment plan can change during the treatment. The commenter also stated that, if a patient received a treatment plan from a dentist, the patient assumes that is all the work

they will need but, sometimes a filling can turn into a root canal or extraction. The commenter stated that dentists cannot tell what can happen in some cases and that [page=630] having a signed treatment plan gives patients an illusion of the treatment needed.

72. COMMENT: One commenter expressed concerns with N.J.A.C. 13:30-8.7. The commenter stated that every change is a significant change and it is unrealistic and administratively overwhelming to have to re-sign the treatment plan each time it is changed. The commenter noted that, in many cases, the treatment plan is constantly evolving. The commenter also noted that it is already a requirement with dental licensure to educate patients, discuss the treatment options, and have informed consent. The commenter contended that the word "significant" is subjective and dentists and patients may disagree as to what is deemed significant. The commenter also contended that requiring an updated signed treatment plan gives the perception that each plan is a binding contract that must be followed when in fact, it is a treatment proposal, which is not a "constant" but a "variable." The commenter asked whether proposals also need to be signed. The commenter stated that adding this provision does not give any added protection for the patient and undermines the dentist-patient relationship by operating like a car repair shop not a doctor's office.

73. COMMENT: One commenter stated that the treatment plan is not a binding contract and should not be treated as one and that it does not protect anyone, not the doctor nor the patient. The commenter also stated that treatment plans for the same patient can vary amongst dentists and that the one that is important can only be determined as treatment progresses. Because patients are not cars and nothing can be predicted, the treatment plan is constantly in flux, often unpredictable, and can change within seconds. The commenter stated that during the first comprehensive exam it is not possible to create a complete treatment plan and that the patient's medical, dental, psychological, and financial history need to be considered before creating a plan. Additional factors include whether the patient has access to care, can visit the office or if they need help, as in cases involving elderly or child patients. The commenter stated that each of these factors can change during a treatment period. The commenter also asked the Board to consider that the patient may give consent to something they really do not understand, and may sign the treatment plan out of trust for the doctor. The commenter noted that completing a treatment plan can take years, and periodic exams could change the previous plan. The commenter questioned, when things change or there are emergency situations, which plan a dentist is accountable for and how this impacts possible malpractice liability. The commenter believes that having a signed treatment plan results in increased administration

load and problems. The commenter recommended further consideration and tabling this proposed amendment until further discussion with more dentists.

74. COMMENT: One commenter objected and expressed concerns with the impracticality of the generalized signed treatment plan proposal because the requirement is unnecessary, excessive, and impractical. The commenter stated that patient treatment plans changes and fluctuate depending on clinical need and cannot be anticipated 100 percent of the time as there are technological limitations to diagnostic tools, patient's occlusal habits and function, and restorative goals. The commenter believes that it is an impossible and laborious to stop and get a signature each time there is a change. The commenter stated that dental insurance is not always sufficient assistance for patients to complete entire treatment plans at an annual pace so interim restorations are sometimes considered to assist the patient. The commenter believes that the new requirement is redundant to patients signing consent forms and requires an incredible amount of storage and delays in clinical flow.

75. COMMENT: One commenter suggested that the Board impose a threshold requirement of treatment plans of more than $ 2,500 to require signed treatment plans. The commenter believes that for a general dentist in a smaller practice, the Board's proposed requirement creates an undue burden for small procedures performed on a daily basis. The commenter believes that for larger treatment plans a signed treatment plan is necessary but that for a simple filled diagnosis in hygiene having a patient sign a form would slow down patient care and create additional clerical work, without providing any significant benefit to the patient.

76. COMMENT: One commenter stated that there are large numbers of incidences in which it is impractical to have a treatment plan or revision thereto "signed by the patient," as proposed with respect to N.J.A.C. 13:30-8.7. The commenter also stated that there are countless doctor-patient relationships, both new and long-standing, where issues regarding treatment and associated costs simply do not exist. The commenter noted that it is understands that the Board receives approximately 500 complaints a year, a large percentage of which are predicated upon a dispute regarding money. The commenter contended that, when viewed in context of the millions of dental procedures performed each year, the number of complaints is miniscule. The commenter also contended that, even when treatment plans are signed, there are likely to be disputes that will arise and, therefore, it does not appear that this additional requirement is necessary or desirable.

RESPONSE TO COMMENTS 66 THROUGH 76: The Board will not adopt the proposed amendments to N.J.A.C. 13:30-8.7(a)4 at this time to further consider whether a regulatory change is necessary and, if so, how to achieve the Board's goal of enhancing transparency and communication between the dentist and patient in a less burdensome manner.

Signage

77. COMMENT: One commenter expressed concerns about the Board's proposed amendment at N.J.A.C. 13:30-8.9(a) requiring the placement of all practice owners to be listed on exterior signage. The commenter contended that there does not exist any substantive reasoning for this and that the important information is who treats the patients. The commenter noted situations where a spouse is a partial owner of the company because of the need to secure financing for business loans. The commenter stated that this also helps in cases where if the dentist were to become deceased, there is no need to "transition" the office. The commenter also noted that many practice buy-outs have the older owner "holding the note" and allowing the new owner to buy-in over a decade, and questioned the purpose served in having that person's name on a sign when the individual is retired. The commenter stated that this is needless intrusion by the State. The commenter suggested that the Board could require having an "on demand" document listing the business owners that can be requested by patients, as well as having a searchable database that the State Board maintains.

78. COMMENT: One commenter stated that proposed amended N.J.A.C. 13:30-8.9(a) requiring the names of the individuals who are "the owners of the facility" instead of the licensees who are "responsible for the administration of the facility" to be displayed on all exterior signs is superfluous. The commenter contended that it is impractical and an unrealistic burden for practices to modify or replace all signage to include the "owners of the facility." The commenter stated that the point of having a sign is to advertise services and location and because many dental practices across the State are practices that have multiple owners or partners, it is far reaching to mandate every owner be listed. The commenter stated that space limitations on signage may make a list of the names of all owners in addition to the name of practice, illegible. In addition, the commenter noted from an economic standpoint, many practices use their name to brand themselves and build their reputation as opposed to the name of the doctors that work in the practice. The commenter also contended that there are many small businesses that have recently invested in new signs that may not have the practice owner's name listed and, therefore, the financial burden to replace a brand new sign is punitive in nature.

79. COMMENT: One commenter contended that signage for businesses to list all owners is cumbersome, restrictive, and not cost effective for dental offices. The commenter stated that this will be difficult for group practices with multiple owners, or with limited signage space. The commenter believes that the requirement is impractical and will not increase patient safety or access to care.

80. COMMENT: One commenter requested that the Board clarify "exterior" because many building exteriors (outdoors) have limited space for signage and making this a requirement will be problematic, may require a variance from the landlord, and be a costly expense. The commenter also questioned the need for the amendment. The commenter stated it could understand if the owners name were to be posted within the office space or on the front door for people actually entering the office.

RESPONSE TO COMMENTS 77, 78, 79, AND 80: After considering the comments received, the Board believes it can accomplish its goal to provide information about dental practice ownership in a less burdensome [page=631] manner. Upon adoption, the Board will not adopt the proposed changes at N.J.A.C. 13:30-8.9(a). Instead, the Board will add new subsection (c) to require that every dental facility offering dental care to the public shall conspicuously display in its office, the names of the licensees who are the owners of the facility. Additional public notice of this change is not necessary because it does not change the effect of this rule. Patients of the practice will still have access to the information about practice ownership.

81. COMMENT: One commenter agreed with the Board's proposed revision at N.J.A.C. 13:30-8.9 to require that the names of "owners" rather than the licensees who are "responsible for administration" be displayed. The commenter, however, recommended that the Board reconsider the remainder of the existing provision because there are facilities at which exterior signs or other means of exterior display are not permitted.

RESPONSE: The Board agrees that information about practice ownership is important. As discussed in the Response to Comments 77, 78, 79, and 80, upon adoption the Board is retaining the existing rule requirement to list on exterior signs those who are responsible for administration of the facility and to require conspicuously displaying inside the facility the names of the owners.

Notification of Conviction of Any Crime or Arrest

82. COMMENT: One commenter expressed support for the intent of proposed new N.J.A.C. 13:30-8.12A requiring notification to the Board in writing within 30 days upon conviction of any crime or arrest, etc.

The commenter, however, requested clarification that the Board does not need, or want, the reporting of every minor traffic violation. The commenter believes that as currently worded, if someone gets a parking ticket, the individual would be in violation of one's licensure if such a ticket was not reported to the Board. The commenter does not believe that this is in the interest of the public health or safety, or an efficient use of the Board's resources and will likely make many individuals risk their dental license needlessly.

RESPONSE: N.J.A.C. 13:30-8.12A specifically provides that parking or speeding violations need not be disclosed. However, motor vehicle violations, such as driving while impaired or intoxicated, must be disclosed.

Economic Impact

83. COMMENT: One commenter disputed the Board's belief that the proposal will not have any effect on the employment of New Jersey workers. The commenter stated that increasing the costs of "doing business," such as $ 20,000 for a back-up generator, $ 2,000-3,000 for new signage, and office down-time to attain the new continuing education requirements, will affect the compensation of employees. The commenter also stated that the trend in New Jersey is to increase employer costs and that higher costs of unemployment insurance and administrative costs, and increased State assessed "fees" all put significant pressure on employee hiring. The commenter noted that it has already outsourced several jobs due to New Jersey "Sick leave" requirements, among other things, and is installing a "Kiosk" to replace a reception staff member. The commenter contended that continuing to pile regulations and costs onto businesses will continue this trend.

RESPONSE: The Board's proposed amendments do not require practices to have a back-up generator. In addition, upon adoption, the Board is no longer requiring changes to the exterior signage (see the Response to Comments 77, 78, 79, and 80). The Board also notes that although certain continuing education topics are required, the total number of mandated continuing education credits has not increased. Therefore, the Board does not believe that there is any additional economic burden for licensees and registrants to satisfy these requirements. State laws that apply to all employers and businesses, including New Jersey "sick leave" requirements, are not related to the Board's rulemaking.

Doctor-Patient Bill of Rights

84. COMMENT: One commenter suggested that the Board and State Legislature should pass legislation that protects both patient and dentist. The commenter believes that a "Doctor-Patient Bill of Rights,"

which protects their relationship from coercion and abuse from dental insurance companies would be welcomed by all parties. The commenter stated that the ability of a multi-million or even multi-billion dollar corporation to bully or intimidate patient and doctor is a very real threat to the quality of dental care in New Jersey. The commenter also stated that, as insurance companies squeeze the profits of dental offices, the number and compensation of employees drops considerably; lab work is outsourced to offshore labs, and ultimately, the quality of care is harmed. The commenter further stated that the goal of the Board primarily is to protect the quality of the Patient-Dentist interaction.

RESPONSE: The Board is aware of myriad pressures upon dental practices that can impact access to care. Dentists, nonetheless, are required to treat patients within the standard of care to ensure a patient's well-being and to always employ ethical business practices.

85. COMMENT: One commenter stated that the comment the Board received from the Monmouth-Ocean County Dental Society (MCODS) was based on an informal consensus of the trustees present at the MCODS Trustee meeting held on January 7, 2020, and that there was no formal motion or vote. The commenter contended that the comments submitted by MCODS do not speak for its 619 members, but are solely the informal consensus of opinions of the trustees who were present at the meeting. The commenter noted that at the general membership meeting conducted on January 14, 2020, there was no discussion about the Board's proposal. The commenter stated that its concerns were shared with the President of the MCODS.

RESPONSE: The Board appreciates the commenter advising the Board of its concern with the submitted comment. The Board, however, considers all comments that are submitted timely and received.

Summary of Agency-Initiated Change:

The Board is making a change at N.J.A.C. 13:30-8.3(d)3 to correct the name of the American Society of Oral and Maxillofacial Surgeons to the American Association of Oral and Maxillofacial Surgeons.

Federal Standards Statement

A Federal standards analysis is not required because the adopted amendments, new rules, and repeal are governed by N.J.S.A. 45:6-1 et seq., and are not subject to any Federal requirements or standards. Although the adopted amendments and new rules are not subject to any Federal requirements or standards, adopted new N.J.A.C. 13:30-8.7(c)7 references compliance with HIPAA and Federal health privacy rule.

Full text of the adopted new rules and amendments follows (additions to proposal indicated in boldface with asterisks ***thus*;** deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 1. LICENSURE TO PRACTICE DENTISTRY

13:30-1.2 Application for licensure to practice dentistry

(a) (No change.)

(b) To qualify as a candidate for dental licensure, an applicant shall submit a completed application to the Board, which shall contain the following information and materials:

1.-2. (No change.)

3. Results from the successful completion of the ADEX dental examination, including the Periodontal Examination, administered by the Commission on Dental Competency Assessments ***and other entities administering the ADEX dental examination***. If an applicant fails any portion of the ADEX dental examination three consecutive times, the Board may require the applicant to sit for, and pass, a remedial course in the subject area ***at a dental program accredited by the Commission on Dental Accreditation*** at a dental school, college, or department of a university *[approved by the Commission on Dental Accreditation]*;

4. (No change.)

5. A certificate of completion of the online New Jersey Jurisprudence orientation taken within six months of the date of application;

6.-9. (No change.)

(c) (No change.)

(d) A candidate for dental licensure who has successfully completed the ADEX dental examination and who has not practiced as a licensed dentist for a period of five years of more prior to the date of application shall re-take the ADEX examination or a Board-approved refresher course with a post-course examination. The Board shall use the results of the clinical or post-course examination to assess competency and practice proficiencies. If the examination identifies deficiencies or educational [page=632] needs, the Board may require the applicant as a condition of licensure to take and successfully complete any education or training or to submit to any supervision, monitoring, or limitations as the Board determines is necessary to assure that the applicant practices with reasonable skill and safety. A candidate for dental licensure shall submit a completed application to the Board, which shall contain the following information and materials:

1.-3. (No change.)

4. A certificate of completion of the online New Jersey Jurisprudence orientation taken within six months of the date of application;

5.-8. (No change.)

(e) A candidate for dental licensure by credentials, who is licensed to practice dentistry in another state or jurisdiction, shall submit a completed application to the Board, which shall contain the following information and materials:

1.-5. (No change.)

6. A certification of completion of the online New Jersey Jurisprudence orientation taken within six months of the date of application;

7.-10. (No change.)

(f) (No change.)

(g) As part of its review of applicants for licensure as a dentist, the Board shall consider and evaluate any prior record of disciplinary action or pending disciplinary action against the applicant, investigation of the applicant in any other state or jurisdiction, reports from the National Practitioner Data Bank (NPDB), and the applicant's complete professional employment history, or actions affecting the applicant's privileges taken by any institution, organization, or employer related to the practice of dentistry or other professional or occupational practice in New Jersey, any other state, the District of Columbia, or in any other jurisdiction.

13:30-1.5 Retired licensure

A licensee who has practiced dentistry for at least 25 years may, upon application to the Board, be licensed as a retired dentist. A retired licensee shall not engage in the practice of dentistry for the entire biennial period in which he or she has been granted retired status. A retired licensee may resume the practice of dentistry upon fulfilling the requirements *[of]* ***at*** N.J.A.C. 13:30-8.6A.

SUBCHAPTER 1A. DENTAL HYGIENISTS

13:30-1A.2 Application for licensure as dental hygienist

(a) (No change.)

(b) An applicant for licensure as a dental hygienist shall submit a completed application to the Board, which shall contain the following information and materials:

1.-2. (No change.)

3. The results of the successful completion of the National Board Dental Hygiene Examination (NBDHE) administered by the Joint Commission on National Dental Examinations (JCNDE);

4. The results of the successful completion of the ADEX dental hygiene examination administered by the Commission on Dental Competency Assessments, except as provided *[in]* ***at*** (d) and (e) below;

5. A certificate of completion of the online New Jersey Jurisprudence orientation taken within six months of the date of application;

6.-8. (No change.)

(c) (No change.)

(d) Upon a written request from an applicant, the Board may grant a waiver of the ADEX dental hygiene examination. The candidate requesting such a waiver shall submit, at a minimum, the following:

1.-2. (No change.)

3. Test results of any state or regional clinical examination other than the ADEX dental hygiene examination. The Board shall recognize successful completion of the examination results for up to five years. After five years, the Board shall review each request for recognition on a case-by-case basis.

(e) The Board shall recognize successful completion of the ADEX dental hygiene examination for up to five years. After five years, the Board shall review each request for recognition of the ADEX dental hygiene examination on a case-by-case basis and may recognize successful completion of the examination provided the candidate submits, at a minimum, a certification by the board of dentistry in every state or jurisdiction in which the applicant holds a license to practice dental hygiene verifying that the applicant's license in that state or jurisdiction is in good standing.

(f) (No change.)

13:30-1A.4 Scope of practice of licensed dental hygienist under general supervision

(a)-(b) (No change.)

(c) School setting. A licensed dental hygienist practicing under the general supervision of a licensed dentist in a school setting:

1. May administer to that school's students, with written parental or guardian consent, preventive measures such as the application of fluorides, pit and fissure sealants, as well as other recognized topical agents, including topical anesthetics, for the prevention of oral disease or associated discomfort and the detection of caries, and may use a curing light for the application of sealants, provided that:

i. (No change.)

ii. When applying sealants, the licensed dental hygienist conforms to the assessment guidelines set forth by the supervising dentist and adheres to acceptable treatment protocol standards, including maintaining a dry field;

2. *[Shall]* ***When making radiographic exposures, shall*** make radiographic exposures as permitted by the Department of Environmental Protection ***,*** pursuant to N.J.S.A. 26:2D-24 et seq., provided that the exposures are made for the school's students and written parental or guardian consent is obtained; and

3. Shall comply with the notification requirements *[of]* ***at*** (f)3 below and provide written notice of the administered treatment to the supervising dentist, school, and parent/guardian.

i.-ii. (No change.)

(d) The supervising dentist of a licensed dental hygienist practicing under the general supervision in a school setting shall:

1. Maintain for at least seven years:

i. (No change.)

ii. The written record of treatment by the licensed dental hygienist; and

2. Review, within 30 days of treatment by the licensed dental hygienist, the written record of treatment to ensure compliance with the assessment guidelines, treatment protocol standards, and notification requirements set forth *[in]* ***at*** (c) above.

i. (No change.)

Recodify existing (d)-(e) as (e)-(f) (No change in text.)

13:30-1A.5 Administration of local anesthesia by licensed dental hygienists

(a)-(c) (No change.)

(d) A licensed dental hygienist applying for a Board permit to administer local anesthesia shall satisfy the following requirements:

1. (No change.)

2. Passage of the written examination in the administration of local anesthesia administered by the Commission on Dental Competency Assessments (CDCA).

(e) A licensed dental hygienist who holds a permit to administer local anesthesia under the direct supervision of a licensed dentist shall complete four hours of continuing education in the administration of local anesthesia in every other biennial renewal period (that is, four hours every four years), consistent with the requirements *[of]* ***at*** N.J.A.C. 13:30-5.2.

(f)-(h) (No change.)

13:30-1A.7 Credit towards licensure as a dental hygienist for education, training, and experience received while serving as a member of the Armed Forces

(a) (No change.)

(b) The Board shall issue a license as a dental hygienist to the applicant if the applicant presents evidence to the Board that:

1.-2. (No change.)

3. The applicant complies with all other requirements for licensure as a dental hygienist, including successful completion of the National Board Dental Hygiene Examination (NBDHE) administered by the Joint [page=633] Commission on National Dental Examinations (JCNDE), the ADEX dental hygiene examination, and the online New Jersey Jurisprudence orientation within six months of the date of application, as set forth *[in]* ***at*** N.J.A.C. 13:30-1A.2.

(c)-(e) (No change.)

SUBCHAPTER 2. DENTAL ASSISTANTS

13:30-2.2 Application for registration as dental assistant

(a) An applicant desiring to secure registration as a dental assistant shall have a certificate of completion of the online New Jersey Jurisprudence orientation taken within six months of the date of application and:

1. Satisfactorily completed and graduated, within the past 10 years, from an educational program for dental assistants approved by the Board and the Commission on Dental Accreditation and shall have taken the Certified Dental Assistant Examination administered by the Dental Assisting National Board (DANB) within 10 years prior to the date of application; or

2. Successfully completed high school (or its equivalent) and shall have:

i. Obtained at least two years of work experience as a dental assistant during the five-year period prior to making application for registration, passed the Certified Dental Assistant Examination administered by DANB within 10 years prior to the date of application, successfully completed a Board-approved program in expanded functions, and passed the New Jersey Expanded Functions Examination administered by DANB; or

ii. Obtained at least two years of work experience as a dental assistant during the five-year period prior to making application for registration, passed the Certified Dental Assistant Examination administered by DANB within 10 years prior to application, and passed the New Jersey Expanded Functions Examination administered by DANB.

(b) An applicant for registration as a dental assistant shall submit a completed application to the Board that contains the following information and materials:

1. (No change.)

2. Proof of the following, if applicable pursuant to (a) above:

i.-ii. (No change.)

iii. A certificate of successful completion of an approved program in expanded functions in dental assisting. The Board shall recognize the following as providers of approved programs in expanded functions:

(1)-(2) (No change.)

(3) In-service training programs conducted at the graduate level by agencies of the Federal, State, or local government that are substantially similar to programs described *[in]* ***at*** (b)2iii(1) and (2) above;

iv. A certificate of successful completion of the *[Registered]* ***Certified*** Dental Assistant *[Certification]* Examination administered by DANB; and

v. A certificate of completion of the online New Jersey Jurisprudence orientation within six months of the date of application;

3.-4. (No change.)

13:30-2.3 Application for registration as limited registered dental assistant in orthodontics

(a) An applicant desiring to secure registration as a limited registered dental assistant in orthodontics shall have a certificate of completion of the online New Jersey Jurisprudence orientation taken within six months of the date of application and:

1.-2. (No change.)

(b) An applicant for registration as a limited registered dental assistant in orthodontics shall submit a completed application to the Board that contains the following information and materials:

1.-2. (No change.)

3. A certificate of successful completion of the Certified Orthodontic Assistant (COA) Examination, or successor examination, administered by DANB, the Topical Fluoride Examination, or successor examination, administered by DANB, the Coronal Polish Examination, or successor examination, administered by DANB, and a certificate of completion of the online New Jersey Jurisprudence orientation within six months of the date of application;

4.-5. (No change.)

13:30-2.7 Credit towards registration as a dental assistant for education, training, and experience received while serving as a member of the Armed Forces

(a) (No change.)

(b) The Board shall issue a registration as a dental assistant to the applicant if the applicant presents evidence to the Board that:

1.-2. (No change.)

3. The applicant complies with all other requirements for registration, including successful completion of the Certified Dental Assistant Examination administered by the Dental Assisting National Board (DANB), the New Jersey Expanded Functions Examination administered by DANB, as applicable, as set forth at N.J.A.C. 13:30-2.2, and completion of the online New Jersey Jurisprudence orientation within six months of the date of application.

(c)-(e) (No change.)

13:30-2.8 Credit towards registration as a limited registered dental assistant in orthodontics for education, training, and experience received while serving as a member of the Armed Forces

(a) (No change.)

(b) The Board shall issue a registration as a limited registered dental assistant in orthodontics to the applicant if the applicant presents evidence to the Board that:

1.-2. (No change.)

3. The applicant complies with all other requirements for registration, including successful completion of the examination requirements as set forth at N.J.A.C. 13:30-2.3, and completion of the online New Jersey Jurisprudence orientation within six months of the date of application.

(c)-(e) (No change.)

SUBCHAPTER 3. APPLICANTS FOR LIMITED TEACHING CERTIFICATE IN A DENTAL SCHOOL

13:30-3.1 Qualifications of applicants

(a) (No change.)

(b) An applicant for such limited license must have the competency to teach the science of dentistry as predicated upon the applicant's general and technical knowledge.

(c) An applicant for a limited teaching certificate shall submit a certified transcript from the secretary or dean of a dental school, college, or department of a university, verifying that the applicant has obtained a dental degree from such institution.

13:30-3.2 Application procedure

(a) The applicant for a limited teaching certificate shall:

1. Submit a completed and notarized application, which shall include a certified transcript of graduation from a dental school by an authorized official of the dental school;

2. Provide employment history and professional history from the time the dental degree was conferred; and

3. (No change in text.)

(b) In addition to the requirements *[of]* ***at*** (a) above, the dean of the dental school in which the applicant seeks employment shall submit to the Board:

1. A certification that the applicant is properly qualified to teach, demonstrate, and practice dentistry at the dental school; and

2. Supporting information from which the Board can determine that the applicant's general and technical level of knowledge and moral character suitably qualifies the applicant to teach, demonstrate, and practice dentistry at a dental school in this State.

13:30-3.3 Limitations on certificate

(a) (No change.)

(b) No limited teaching certificate shall be deemed to authorize the licensee to engage in the private practice of dentistry outside of the premises of the dental school or its clinical facilities.

(c) A limited teaching certificate shall automatically expire upon the termination of the certificate holder's employment by a dental school in this State.

[page=634] 13:30-3.4 Educational institutions

(a)-(b) (No change.)

(c) No dental school in this State shall employ, at any one time, more than 15 persons with limited teaching certificates who have graduated from dental schools not approved by the Board. For the purposes of this subsection, if the dental school from which the applicant graduated is located in the United States, Canada, or a territory or possession of the United States, the dental school shall be approved by the Board.

SUBCHAPTER 5. CONTINUING EDUCATION

13:30-5.1 Continuing dental education requirements for dentists

(a) Continuing education shall be a mandatory requirement for license renewal, except that the Board shall not require completion of continuing dental education credits for initial registration of dentists. All licensed dentists holding active licenses shall submit a certification verifying completion of 40 hours of continuing dental education every two years at the time of registration renewal, including the 10 mandatory hours of continuing dental education specified *[in]* ***at*** (e) below, except for the following:

1.-2. (No change.)

(b)-(d) (No change.)

(e) All continuing education activities to be accepted for credit shall have significant intellectual or practical content, which deals primarily with matters directly related to the practice of dentistry or with the professional responsibilities or ethical obligations of licensees.

1. The following 10 hours of continuing education shall be completed by each licensee during each biennial renewal period ***,*** as required *[in]* ***at*** (a) above:

i. Three hours of continuing education with practical hands-on certification for cardiopulmonary resuscitation (CPR), which meets the American Heart Association certification standards for healthcare providers. The training shall include the use of an automatic external defibrillator (AED), unconscious and conscious choking, and rescue breathing. Webinars and electronic media distance learning courses shall not satisfy this requirement;

ii. Three hours of continuing education of pharmacology and internal medicine, which includes the appropriate use of analgesics, antibiotics, local anesthesia and agents to control anxiety, drug (medication) knowledge and interactions, prescription writing, abuse of prescriptions by patients, taking complete medical histories, and the use of the New Jersey Prescription Monitoring Program (NJPMP);

iii. Two hours of continuing education in preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control in dental settings. Examples of such education include: modes of disease transmission and the chain of infection; strategies that can prevent occupational exposures to blood and bodily fluids; methods to ensure that patient-care items and environmental surfaces are safe for use; selection and use of safe dental devices and dental water quality assurance and practice monitoring; and evaluation of dental infection control programs;

iv. One hour of continuing education in professional ethics and New Jersey law concerning the practice of dentistry. Examples of such education include: dental ethics, professionalism, New Jersey jurisprudence, ethical issues concerning the abuse of prescriptions by patients, child abuse, competence and judgment, and patient confidentiality. The online New Jersey Jurisprudence orientation shall not satisfy this continuing education requirement; and

v. Pursuant to P.L. 2017, c. 28, one hour of continuing education in educational programs or topics concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids

for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion. This one credit shall not be eligible for carry-over as described *[in]* ***at*** (k) below.

2. In accordance with P.L. 2017, c. 28, if the Board deems it appropriate, on an individual basis, the Board may waive the specific one credit continuing education requirement concerning prescription opioid drugs. Any such waiver request shall be filed pursuant to (m) below.

3. Notwithstanding the exemption from the completion of continuing education credits as set forth *[in]* ***at*** (a)2 above, the applicant, once licensed by the Board, shall complete, within 24 months of becoming licensed, one credit in educational programs or topics concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion.

4. The Board shall not accept the following topics for continuing education credit:

i. Estate planning;

ii. Financial or investment/tax planning; or

iii. Personal health.

(f)-(h) (No change.)

(i) A licensee may obtain continuing education credits from any of the areas of study listed below. A licensee shall not receive credit for more than the maximum number of hours permitted in each area of study for each biennial period, as set forth *[in]* ***at*** (i)1 through 4 below.

1. Educational and scientific courses related to the practice of dentistry*[;]* ***.***

i. (No change.)

ii. The following shall satisfy the requirement of 40 hours of continuing education, including the 10 mandatory hours required *[in]* ***at*** (e) above, for a biennial registration period:

(1) (No change.)

(2) Attendance at, or completion of, an approved advanced education program leading to certification in endodontics, oral and maxillofacial surgery, oral and maxillofacial pathology, orthodontics, pediatric

dentistry, periodontics, prosthodontics, public health, or oral and maxillofacial radiology.

iii. (No change.)

iv. A maximum of 20 hours of continuing education credit shall be given for any form of written or electronic media distance learning courses. A written or electronic media distance learning course shall include a written post-test, and such test shall be retained by the licensee as an additional record of completion of the course. Webinars shall not be considered electronic media distance learning courses if they are live (not previously recorded) and synchronous (the instructor and licensee interact with each other in real time).

v. (No change.)

2.-4. (No change.)

(j)-(m) (No change.)

(n) Pursuant to N.J.S.A. 45:6-10.4, consistent with the provisions of this subsection, the Board shall waive up to one-half of the required biennial continuing dental education hours set forth *[in]* ***at*** (a) above for a licensee who renders volunteer dental services to eligible persons.

1. For purposes of this subsection, the following words and terms shall have the following meanings, unless the context clearly indicates otherwise:

"Eligible person" means:

(1) Any person under the age of 19 whose parent or guardian attests that he or she meets the eligibility requirements for, and is enrolled in, the NJ FamilyCare Program established pursuant to P.L. 2005, c. 156 (N.J.S.A. 30:4J-8 et seq.);

(2) A child who is in the custody of the Division of Child Protection and Permanency in the Department of Children and Families; or

(3) Any person who attests that he or she meets the eligibility requirements for, and is enrolled in, the Medicaid program established pursuant to P.L. 1968, c. 413 (N.J.S.A. 30:4D-1 et seq.), the Pharmaceutical Assistance to the Aged and Disabled program established pursuant to P.L. 1975, c. 194 (N.J.S.A. 30:4D-20 et seq.), or the Senior Gold Prescription Discount Program established pursuant to P.L. 2001, c. 96 (N.J.S.A. 30:4D-43 et seq.).

"Volunteer dental service" means dental care provided, without charge, to an eligible person, or to a minor in a primary school,

secondary school, or other school setting, or to a patient through a dental clinic as defined by section 1 of P.L. 1951, c. 199 (N.J.S.A. 45:6-15.1), consistent with the requirements of this subsection.

2. One half-hour of one continuing dental education credit hour shall be waived for each hour of volunteer dental service.

3. The 10 mandatory continuing education hours set forth *[in]* ***at*** (e) above shall not be eligible for waiver.

[page=635] 4. As part of biennial renewal, a licensee shall submit to the Board, on a form supplied by the Board and available on the Board's website at http://www.njconsumeraffairs.gov/den, documentation evidencing the total number of credits that are eligible for the waiver in accordance with this subsection.

13:30-5.2 Continuing education requirements for dental hygienists

(a) All licensed dental hygienists shall submit a certification verifying the completion of 20 hours of continuing education every two years at the time of license renewal, except as provided *[in]* ***at*** (b) and (d) below, including the six mandatory continuing education credits specified in this subsection. No more than one-half of the required continuing education hours in the two-year period may be obtained through written or electronic media distance learning courses. Webinars shall not be considered electronic media distance learning courses if they are live (not previously recorded) and synchronous (the instructor and licensee interact with each other in real time).

1. The following six hours of continuing education shall be completed by each licensee during each biennial renewal period:

i. Three hours of continuing education with practical hands-on certification for cardiopulmonary resuscitation (CPR) that meets the American Heart Association certification standards for healthcare providers. The training shall include the use of an automatic external defibrillator (AED), unconscious and conscious choking, and rescue breathing. Webinars and electronic media distance learning courses shall not satisfy this requirement;

ii. One hour of continuing education in preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control in dental settings. Examples of such education include: modes of disease transmission and the chain of infection; strategies that can prevent occupational exposures to blood and bodily fluids; methods to ensure that patient-care items and environmental surfaces are safe for use; selection and use of safe

dental devices and dental water quality assurance and practice monitoring; and evaluation of dental infection control programs;

iii. One hour of continuing education in professional ethics and New Jersey law concerning the practice of dental hygiene. Examples of such education include: dental ethics, professionalism, New Jersey jurisprudence, ethical issues concerning the abuse of prescriptions by patients, child abuse, competence and judgment, and patient confidentiality. The online New Jersey Jurisprudence orientation shall not satisfy this continuing education requirement; and

iv. One hour of continuing education in educational programs or topics concerning prescription opioid drugs, including the risks and signs of opioid abuse, addiction, and diversion.

(b)-(f) (No change.)

(g) Consistent with the provisions of this subsection, the Board shall waive up to one-half of the required biennial continuing dental hygiene education hours set forth *[in]* ***at*** (a) above for a licensee who renders volunteer services as a clinician to eligible persons as defined at N.J.A.C. 13:30-5.1(n).

1. One half-hour of one continuing dental hygiene education credit hour shall be waived for each hour of volunteer clinician service. "Volunteer clinician service" means clinician services provided, without charge, to an eligible person, as defined at N.J.A.C. 13:30-5.1(n), or to a minor in a primary school, secondary school, or other school setting, or to a patient through a dental clinic as defined by section 1 of P.L. 1951, c. 199 (N.J.S.A. 45:6-15.1), consistent with the requirements of this subsection.

2. The six mandatory continuing education hours set forth *[in]* ***at*** (a)1 above shall not be eligible for waiver.

3. As part of the biennial renewal, a licensee shall submit to the Board, on a form supplied by the Board and available on the Board's website at http://www.njconsumeraffairs.gov/den, documentation evidencing the total number of credits that are eligible for the waiver in accordance with this subsection.

13:30-5.3 Continuing education requirements for registered dental assistants and limited registered dental assistants in orthodontics

(a) All registered dental assistants and limited registered dental assistants in orthodontics shall submit a certification verifying the completion of 10 hours of continuing education every two years at the time of registration renewal, including the six mandatory continuing education hours set forth *[in]* ***at*** (f) below. No more than one-

half of the required continuing education hours in the two-year period may be obtained through written or electronic media distance learning courses. Webinars shall not be considered electronic media distance learning courses if they are live (not previously recorded) and synchronous (the instructor and registrant interact with each other in real time).

(b)-(e) (No change.)

(f) The following six hours of continuing education shall be completed by each registrant during each biennial renewal period:

1. Three hours of continuing education with practical hands-on certification for cardiopulmonary resuscitation (CPR), which meets the American Heart Association certification standards for healthcare providers. The training shall include the use of an automatic external defibrillator (AED), unconscious and conscious choking, and rescue breathing. Webinars and electronic media distance learning courses shall not satisfy this requirement;

2. One hour of continuing education in preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control in dental settings. Examples of such education include: modes of disease transmission and the chain of infection; strategies that can prevent occupational exposures to blood and bodily fluids; methods to ensure that patient-care items and environmental surfaces are safe for use; selection and use of safe dental devices and dental water quality assurance and practice monitoring; and evaluation of dental infection control programs;

3. One hour of continuing education in professional ethics and New Jersey law concerning the practice of dental assisting. Examples of such education include: dental ethics, professionalism, New Jersey jurisprudence, ethical issues concerning the abuse of prescriptions by patients, child abuse, competence and judgment, and patient confidentiality. The online New Jersey Jurisprudence orientation shall not satisfy this continuing education requirement; and

4. One hour of continuing education in educational programs or topics concerning prescription opioid drugs, including the risks and signs of opioid abuse, addiction, and diversion.

(g) Consistent with the provisions of this subsection, the Board shall waive up to two of the required biennial continuing dental assistant education hours set forth *[in]* ***at*** (a) above for a registrant who renders volunteer services as a clinician to eligible persons as defined at N.J.A.C. 13:30-5.1(n).

1. One half-hour of one continuing dental assisting education credit hour shall be waived for each hour of volunteer clinician service. "Volunteer clinician service" means clinician services provided, without charge, to an eligible person, as defined at N.J.A.C. 13:30-5.1(n), or to a minor in a primary school, secondary school, or other school setting, or to a patient through a dental clinic as defined by section 1 of P.L. 1951, c. 199 (N.J.S.A. 45:6-15.1), consistent with the requirements of this subsection.

2. The six mandatory continuing education hours set forth *[in]* ***at*** (f) above shall not be eligible for waiver.

3. As part of the biennial renewal, a registrant shall submit to the Board, on a form supplied by the Board and available on the Board's website at http://www.njconsumeraffairs.gov/den, documentation evidencing the total number of credits that are eligible for the waiver in accordance with this subsection.

SUBCHAPTER 6. ADVERTISING

13:30-6.2 Professional advertising

(a)-(o) (No change.)

(p) A licensee shall be presumed to have approved and shall be personally responsible for the form and contents of an advertisement that contains the licensee's name, office address, or telephone number or [page=636] which is published or caused to be published by an entity to which the licensee has paid a fee or when the licensee has agreed to have his or her name listed as a participant pursuant to (q) below. A licensee who employs or allows another to employ for his or her benefit an intermediary source or other agent in the course of advertising shall be personally responsible for the form and contents of the advertisement.

(q)-(r) (No change.)

(s) A dentist advertising sedation services who uses the terms "sleep," "sleep dentistry," "sleeplike-state," or any similar words or combinations thereof in connection with the provision of dental services shall be considered to be inducing deep sedation as defined at N.J.A.C. 13:30-8.1A(a) and shall comply with the requirements of N.J.A.C. 13:30-8.3.

SUBCHAPTER 8. GENERAL PROVISIONS

13:30-8.1 Fee schedules

(a) The application fees charged by the New Jersey State Board of Dentistry shall be the following:

1.-3. (No change.)

(b) The biennial license and registration fees charged by the New Jersey State Board of Dentistry shall be the following:

1. Dentists:

i.-ii. (No change.)

iii. (Reserved)

iv.-v. (No change.)

2. Dental Hygienists

i.-ii. (No change.)

3. Registered Dental Assistants, Limited Registered Dental Assistants and Limited Registered Orthodontic Assistants:

i.-ii. (No change.)

(c)-(d) (No change.)

(e) Other fees:

1.-2. (No change.)

3. Licensure of dentists by credentials--application fee ..... $ 125.00

4.-8. (No change.)

(f) (No change.)

13:30-8.2 Parenteral conscious sedation

(a)-(b) (No change.)

(c) No dentist shall use PCS for dental patients unless such dentist possesses a PCS permit issued by the State Board of Dentistry for a specified practice location, which shall be renewed biennially. A dentist shall obtain a separate PCS permit for each practice location at which PCS is administered, except as set forth *[in]* ***at*** (l) below.

(d) A dentist applying for a Board permit to administer PCS shall complete an application as provided by the Board. The dentist shall submit as part of a completed application a certification from an

accredited university, teaching hospital, or other training institution or facility approved pursuant to N.J.S.A. 45:6-2, establishing that the applicant has completed formal training in the administration of PCS. Such formal training shall consist of, at a minimum, 40 hours in didactic instruction and 40 hours of supervised clinical training in the administration of PCS. Such formal training shall have been completed within three years preceding the date of application. Supervised clinical training shall consist of, at a minimum, delivering intravenous, intramuscular, subcutaneous, submucosal and inhalation medications, monitoring patient activity, and managing patient care for 20 PCS patients. As part of the dentist's PCS permit application, the institution shall certify the applicant is competent to:

1.-4. (No change.)

5. Understand the clinical pharmacology of the drugs used for PCS and the interactions of these drugs;

6. (No change.)

7. Monitor patients during the administration of PCS using clinical evaluations and mechanical means, including the use of an EKG monitor and a pulse oximeter, capnography, and the interpretation of such readings;

Recodify existing 9.-10. as 8.-9. (No change in text.)

(e) (Reserved)

(f) A licensee who administers parenteral conscious sedation shall:

1. Be able to recognize and manage complications and medical emergencies from drug administrations;

2. Understand the clinical pharmacology of the drugs used for parenteral conscious sedation and the interactions of these drugs;

3. Maintain patient airways and support ventilation;

4. Monitor patients during the administration of parenteral conscious sedation using clinical evaluations and mechanical means, including the use of an EKG monitor, pulse oximeter, and capnogram, and the interpretation of such readings;

5. Manage patients during the post-operative period and assess patients' suitability for discharge; and

6. Maintain accurate and contemporaneous anesthetic records including drugs, dosages, vital signs, and patient responses.

(g) An applicant for a PCS permit shall obtain emergency training by completing the American Heart Association course in Basic Life Support for Healthcare Professionals, or its equivalent, and a course in Advanced Cardiac Life Support, or its equivalent, and shall maintain current certification in such courses. The applicant shall furnish proof of this training and certification to the Board upon application for a PCS permit and proof of recertification upon biennial renewal of the permit.

(h) An applicant for a PCS permit shall certify to the Board upon application for a permit and upon biennial renewal of the permit that the dentist employs no fewer than two persons who will be present in the office, at least one of whom shall assist in monitoring the patient whenever PCS is employed. The applicant shall further certify that these persons are trained in, and capable of, monitoring vital signs and of assisting in emergency procedures and that they maintain current certification in ***the*** American Heart Association course in Basic Life Support for Healthcare Professionals, or its equivalent, *[and]* ***or*** in Advanced Cardiac Life Support, or its equivalent.

(i) An applicant for a PCS permit shall certify as part of the application for a permit and upon biennial renewal of the permit that he or she possesses basic equipment and supplies to deal with emergency situations. The permit holder's facility shall contain the following readily accessible and properly operating equipment:

1. Emergency drug kit, consisting of, at a minimum, the following:

i. Analgesics;

ii. Local anesthetics;

iii. Vasopressors;

iv. Vasodilators (coronary);

v. Anti-bradicardic agents;

vi. Bronchodilators;

vii. Muscle relaxant for treatment of laryngospasm;

viii. Antihistamine;

ix. Narcotic antagonist;

x. Anticonvulsant;

xi. Steroids;

xii. Tranquilizers;

xiii. Anti-hypertensive;

xiv. Benzodiazepines;

xv. Benzodiazepine antagonist;

xvi. Anti-arrhythmic (for example, lidocaine or amiodarone);

xvii. Aspirin;

xviii. Nitroglycerine (tablets, paste, or spray);

xix. Antiemetic; and

xx. Dantrolene ***for those practice locations where succinylcholine is used routinely, but not for emergency use, or where halogenated hydrocarbon general anesthetic inhalation agents are used***;

2. Battery-powered clocks or watches;

3. Stethoscope;

4. Mouth props (assorted adult and pediatric sizes);

5. Suction equipment capable of aspirating gastric contents from the mouth and pharynx;

6. Emergency suction device;

7. Nasopharyngeal tubes;

8. Oropharyngeal tubes;

9. A blood pressure monitoring device;

10. An EKG monitor;

11. A pulse oximeter or its equivalent;

[page=637] 12. Respiration monitoring equipment (for example, visible reservoir bag);

13. Intravenous solutions ("ACLS compatible" IV administration sets and tubing);

14. Syringes, needles, IV catheters, and tape scissors;

15. Laryngoscopes, assorted size blades, and spare batteries;

16. Endotracheal tubes (adult and pediatric sizes);

17. Magil forceps;

18. Yankauer type suction tips and catheter suction; and

19. A capnometer.

(j) (No change in text.)

(k) A dentist who utilizes the services of a PCS permit holder or an M.D. or D.O. who is a member of the anesthesiology staff of an accredited hospital or who is authorized to perform anesthesia services by the Board of Medical Examiners pursuant to N.J.A.C. 13:35-4A shall not be deemed to be administering PCS, provided that the PCS permit holder or M.D. or D.O. remains present during the administration of PCS through patient discharge, and bears full responsibility during the entire procedure until the patient has recovered fully and has been discharged.

(l) A PCS permit holder invited by a dentist to provide PCS services at a specific location shall bear full responsibility for compliance with all provisions of this section including the minimum requirements for assisting staff and equipment set forth *[in]* ***at*** (e), (h), and (i) above. When a PCS permit holder utilizes mobile equipment and supplies to administer PCS pursuant to this section, the mobile equipment, drugs, and supplies of the permit holder shall be inspected by the Board or its designee not less than once every three years. "Mobile equipment, drugs, and supplies," for purposes of this subsection, means any equipment, drugs, and/or supplies that are transported and used by a permit holder to administer PCS in one or more locations. When more than one permit holder utilizes the mobile equipment and supplies, it shall be the responsibility of the permit holder using the equipment and supplies to ensure that the mobile equipment, drugs, and supplies satisfy the requirements of this section as set forth *[in]* ***at*** (i) above prior to the administration of PCS.

(m) Prior to the administration of a PCS agent, the permit holder shall conduct a physical evaluation of the patient, review the patient's up-to-date medical history, which shall include any changes and any medications, including natural and homeopathic medications, allergies, and sensitivities. The patient history shall be maintained in the files of each dentist for a period of not less than seven years. Specific contemporaneous records on the use of PCS shall be kept as part of every patient chart and shall include the agents utilized, the dosage, and the duration of sedation. The patient record, including medical history, shall be maintained in accordance with N.J.A.C. 13:30-8.7.

Recodify existing (l)-(m) as (n)-(o) (No change in text.)

13:30-8.3 Use of general anesthesia

(a)-(b) (No change.)

(c) No dentist shall employ or use general anesthesia on an outpatient basis for dental patients unless such dentist possesses a permit or authorization issued by the State Board of Dentistry for a specified practice location, which shall be renewed biennially. A dentist shall obtain a separate general anesthesia permit for each practice location at which general anesthesia is administered, except as set forth *[in]* ***at*** (i) below.

(d) In order to receive *[such]* a permit ***pursuant to (c) above*,** the dentist shall apply on an official application form and submit certified or verifiable proof of the following:

1. Completion of a minimum of three years of post-doctoral training in oral surgery, or a minimum one-year training course in anesthesiology; or

2. Being a diplomate in oral surgery or is Board-eligible in oral surgery; or

3. Being a fellow of the American Dental Society of Anesthesiology, or is a member of the American *[Society]* ***Association*** of Oral and Maxillofacial Surgeons and/or is a member of the New Jersey Society of Oral and Maxillofacial Surgeons.

(e) (No change.)

(f) Every applicant for a general anesthesia permit must certify that he or she possesses basic equipment and supplies to deal with emergency situations, as required by the Board, which shall be readily accessible and maintained in good operating condition. The permit holder's facility shall contain the following readily accessible and properly operating equipment:

1. Emergency drug kit, consisting of, at a minimum, the following:

i. Analgesics;

ii. Local anesthetics;

iii. Vasopressors;

iv. Vasodilators (coronary);

v. Anti-bradicardic agents;

vi. Bronchodilators;

vii. Muscle relaxant for treatment of laryngospasm;

viii. Antihistamine;

ix. Narcotic antagonist;

x. Anticonvulsant;

xi. Steroids;

xii. Tranquilizers;

xiii. Anti-hypertensive;

xiv. Benzodiazepines;

xv. Benzodiazepine antagonist;

xvi. Anti-arrhythmic (for example, lidocaine or amiodarone);

xvii. Aspirin;

xviii. Nitroglycerine (tablets, paste, or spray);

xix. Antiemetic; and

xx. Dantrolene ***for those practice locations where succinylcholine is used routinely, but not for emergency use, or where halogenated hydrocarbon general anesthetic inhalation agents are used***;

2. Battery-powered clocks or watches;

3. Stethoscope;

4. Mouth props (assorted adult and pediatric sizes);

5. Suction equipment capable of aspirating gastric contents from the mouth and pharynx;

6. Emergency suction device;

7. Nasopharyngeal tubes;

8. Oropharyngeal tubes;

9. A blood pressure monitoring device;

10. An EKG monitor;

11. A pulse oximeter or its equivalent;

12. Respiration monitoring equipment (for example, visible reservoir bag);

13. Intravenous solutions ("ACLS compatible" IV administration sets and tubing);

14. Syringes, needles, IV catheters, and tape scissors;

15. Laryngoscopes, assorted size blades, and spare batteries;

16. Endotracheal tubes (adult and pediatric sizes);

17. Magil forceps;

18. Yankauer type suction tips and catheter suction; and

19. A capnometer.

(g) Any permit holder invited by a dentist to provide general anesthesia services shall be responsible for compliance with all terms and conditions of this section, including the minimum requirements for assisting staff, as set forth *[in]* ***at*** (e) above, equipment, as set forth *[in]* ***at*** (f) above, and facility standards as set forth *[in]* ***at*** (j) below.

(h) (No change.)

(i) In a dental facility where a permit holder administers general anesthesia pursuant to this section, the mobile equipment, drugs, and supplies of the permit holder shall be inspected and approved by the State Board of Dentistry or its designee once every three years. "Mobile equipment, drugs, and supplies," for purposes of this subsection, means any equipment, drugs, and/or supplies that are transported and used by a permit holder to administer anesthesia in one or more dental facilities.

(j) All offices in which general anesthesia is administered shall, at a minimum, have the equipment and supplies as set forth at (f) above and N.J.A.C. 13:30-8.6, which shall be readily accessible and maintained in good operating condition and shall meet the following standards:

1. An operating room with space large enough to provide adequate accommodation of the patient on a table or in an operating chair, and allow an operating team consisting of at least three individuals to move about the patient without restriction or limitation;

[page=638] 2. A recovery area that has available oxygen and monitoring equipment, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theatre; and

3. A lighting system adequate to permit visual evaluation of the patient's skin and mucosal color.

Recodify existing (j)-(k) as (k)-(l) (No change in text.)

(m) Prior to the administration of an anesthetic agent, the permit holder shall conduct a physical evaluation of the patient, review the patient's up-to-date medical history, which shall include any changes and any medications, including natural and homeopathic medications, allergies, and sensitivities. The patient history shall be maintained in the files of each dentist for a period of not less than seven years succeeding the taking of the same. Specific contemporaneous records on use of general anesthesia shall be kept and shall include the agents utilized, dosage, and duration. The patient record, including medical history, shall be maintained in accordance with N.J.A.C. 13:30-8.7.

(n) Any dentist who utilizes the services of a general anesthesia permit holder or an M.D. or D.O. who is a member of the anesthesiology staff of an accredited hospital or who is authorized to perform anesthesia services by the Board of Medical Examiners pursuant to N.J.A.C. 13:35-4A shall not be deemed to be practicing general anesthesia provided that the general anesthesia permit holder or M.D. or D.O. remains present through patient discharge and bears full responsibility during the entire procedure and until any patient regains consciousness. Any general anesthesia permit holder invited by a dentist to provide general anesthesia services shall bear full responsibility for compliance with all terms and conditions of this rule including, but not limited to, the minimum requirements for equipment and assisting staff.

(o) A licensee who administers general anesthesia shall:

1. Be able to recognize and manage complications and medical emergencies from general anesthetic drug administrations;

2. Understand the clinical pharmacology of the drugs used for general anesthesia and the interactions of these drugs;

3. Maintain patient airways and support ventilation;

4. Monitor patients during the administration of general anesthesia using clinical evaluations and mechanical means, including the use of an EKG monitor, pulse oximeter, and capnogram, and the interpretation of such readings;

5. Manage patients during the post-operative period and assess patients' suitability for discharge; and

6. Maintain accurate anesthetic contemporaneous records including drugs, dosages, vital signs, and patient responses.

(p) Every applicant for a permit to use general anesthesia must obtain emergency training by completing the American Heart Association course in Basic Life Support for Healthcare Professionals, or its

equivalent, and a course in Advanced Cardiac Life Support, or its equivalent, and must maintain current certification in these courses. All persons who assist in monitoring a patient under general anesthesia must have emergency training by completing the American Heart Association course in Basic Life Support for Healthcare Professionals, or its equivalent, *[and]* ***or*** a course in Advanced Cardiac Life Support, or its equivalent. The permit applicant must furnish proof of the training and certification to the Board.

Recodify existing (o)-(p) as (q)-(r) (No change in text.)

13:30-8.4 Enteral sedation with single or multiple pharmacological agents

(a)-(g) (No change.)

(h) An applicant for an enteral sedation permit shall obtain emergency training by completing the American Heart Association Basic Life Support for Healthcare Professionals, or its equivalent, and a course in Advanced Cardiac Life Support, or its equivalent, and shall maintain current certification in such course. The applicant shall furnish proof of this training and certification to the Board upon application for an enteral sedation permit and proof of recertification upon biennial renewal of the permit.

(i) A dentist may administer, dispense, or prescribe enteral sedation medications for purposes of dental treatment and its management in a dental treatment setting and shall:

1. (No change.)

2. Be prepared to manage any reasonably foreseeable complications, including, but not limited to, being capable of rescuing the patient from a deeper level of sedation than intended and from a level other than anxiolysis that has produced sedation; and

3. (No change.)

(j) An applicant for an enteral sedation permit shall certify to the Board upon application for a permit and upon biennial renewal of the permit that the dentist employs a licensed health care professional who will be present in the office, trained to assist in the monitoring of the patient whenever enteral sedation is employed. The applicant shall further certify such health care professional is trained in, and capable of, monitoring vital signs and assisting in emergency procedures and that the health care professional maintains current certification in the American Heart Association course in Basic Life Support for Healthcare Professionals, or its equivalent, *[and]* ***or*** in Advanced Cardiac Life Support, or its equivalent.

(k) An applicant for an enteral sedation permit shall certify as part of the application for a permit and upon biennial renewal of the permit that he or she possesses basic equipment and supplies to deal with emergency situations, as required by the Board, which shall be readily accessible and maintained in good operating condition. In addition to the equipment and supplies set forth at N.J.A.C. 13:30-8.26, the permit holder's facility shall contain the following readily accessible and properly operating equipment:

1. (No change.)

2. Emergency suction device;

3. Mouth props (assorted adult and pediatric sizes);

4. Blood pressure monitoring device;

5. A pulse oximeter or its equivalent;

6. An emergency drug kit consisting of, at a minimum, the following:

i. Analgesics;

ii. Local anesthetics;

iii. Vasopressors;

iv. Vasodilators (coronary);

v. Anti-bradicardic agents;

vi. Bronchodilators;

vii. A muscle relaxant for treatment of laryngospasm;

viii. Antihistamine;

ix. A narcotic antagonist;

x. An anticonvulsant;

xi. Steroids;

xii. Tranquilizers;

xiii. Anti-hypertensive;

xiv. Benzodiazepines;

xv. Benzodiazepine antagonist;

xvi. Anti-arrhythmic (for example, lidocaine, amiodarone);

xvii. Aspirin;

xviii. Nitroglycerine (tablets, paste, or spray); ***and***

xix. An antiemetic; *[and]*

[xx. Dantrolene;]

7. Battery-powered clocks or watches; and

8. Yankauer type suction tips and catheter suction.

(l) Prior to the administration, dispensing, or prescribing of enteral sedation, the permit holder shall conduct a physical evaluation of the patient, review the patient's up-to-date medical history, which shall include any changes and any medications, including natural and homeopathic medications, allergies, and sensitivities. The patient history shall be maintained in the patient's record for a period of not less than seven years. Specific contemporaneous notations on the use of enteral sedation shall be kept as part of every patient record and shall include the agents utilized, the dosage, the duration of sedation, the patient's vital signs during administration and recovery, and any untoward reaction. The patient record, including medical history, shall be maintained in accordance with N.J.A.C. 13:30-8.7.

(m)-(n) (No change.)

(o) A dentist who utilizes the services of an enteral sedation permit holder or an M.D. or D.O. who is a member of the anesthesiology staff of an accredited hospital or who is authorized to perform anesthesia services by the Board of Medical Examiners pursuant to N.J.A.C. 13:35-4A shall not be deemed to be administering enteral sedation, provided that the [page=639] enteral sedation permit holder, M.D. or D.O. remains present during the administration of the enteral sedation through patient discharge, and bears full responsibility during the entire procedure until the patient has recovered fully and has been discharged.

(p) An enteral sedation permit holder invited by a dentist to provide enteral sedation services at a specific location shall bear full responsibility for compliance with all provisions of this section including the minimum requirements for assisting staff and equipment set forth *[in]* ***at*** (j) and (k) above. When an enteral sedation permit holder utilizes mobile equipment and supplies to administer enteral sedation pursuant to this section, the mobile equipment, drugs, and supplies of the permit holder shall be inspected by the Board or its designee not less than once every three years. "Mobile equipment, drugs, and supplies," for purposes of this subsection, means any equipment, drugs, and/or supplies which are transported and used by a

permit holder to administer enteral sedation in one or more locations. When more than one permit holder utilizes the mobile equipment, drugs, and supplies, it shall be the responsibility of the permit holder using the equipment, drugs, and supplies to ensure that the mobile equipment and supplies satisfy the requirements of this section as set forth *[in]* ***at*** (k) above prior to the administration of enteral sedation.

13:30-8.5A Infection control education

At least once every biennial renewal period, all licensed dentists shall provide or make available infection prevention education and training to all personnel involved in patient-related sterilization, patient care, and/or maintaining equipment. Such education and training shall include, at a minimum, the topics covered at N.J.A.C. 13:30-5.1(e)1iii.

13:30-8.6 Biennial license and registration renewal

(a) The Board shall send a notice of renewal to each licensee or registrant, at least 60 days prior to the expiration of the license or registration. The notice of renewal shall explain inactive renewal and advise the licensee or registrant of the option to renew as inactive. If the notice to renew is not sent 60 days prior to the expiration date, no monetary penalties or fines shall apply to the holder for failure to renew provided that the license or registration is renewed within 60 days from the date the notice is sent or within 30 days following the date of license or registration expiration, whichever is later.

(b) A licensee or registrant shall renew his or her license or registration for a period of two years from the last expiration date. The licensee or registrant shall submit a renewal application to the Board, along with the renewal fee set forth at N.J.A.C. 13:30-8.1, prior to the date of license or registration expiration.

(c) A licensee or registrant may renew his or her license or registration by choosing inactive status. A licensee or registrant electing to renew his or her license or registration as inactive shall not engage, as applicable, in the practice of dentistry, dental hygiene, or dental assisting, or hold himself or herself out as eligible to engage, as applicable, in the practice of dentistry, dental hygiene, or dental assisting in New Jersey until such time as the license or registration, as applicable, is returned to active status.

(d) If a licensee or registrant does not renew the license or registration prior to its expiration date, the licensee or registrant may renew the license or registration within 30 days of its expiration

by submitting a renewal application, a renewal fee, and a late fee as set forth at N.J.A.C. 13:30-8.1. During this 30-day period, the license or registration shall be valid and the licensee or registrant shall not be deemed practicing without a license or registration, as applicable.

(e) A licensee or registrant who fails to submit a renewal application within 30 days of license or registration expiration shall have his or her license or registration, as applicable, suspended without a hearing.

(f) A licensee or registrant who continues to engage in the practice of dentistry, dental hygiene, or dental assisting, as applicable, with a suspended license or registration shall be deemed to be engaging in the unauthorized practice of dentistry, dental hygiene, or dental assisting, as applicable, and shall be subject to action consistent with N.J.S.A. 45:1-14 et seq., even if no notice of suspension has been provided to the individual.

13:30-8.6A License and registration reactivation

(a) A licensee or registrant who holds an inactive license or registration, pursuant to N.J.A.C. 13:30-8.6(c), or a retired license pursuant to N.J.A.C. 13:30-1.5, may apply to the Board for reactivation of the inactive or retired license or inactive registration. A licensee or registrant seeking reactivation of an inactive or retired license or inactive registration shall submit:

1. A renewal application;

2. A certification of employment listing each job held during the period the license or registration was inactive, which includes the name, address, and telephone number of each employer;

3. The renewal fee for the biennial period for which reactivation is sought as set forth at N.J.A.C. 13:30-8.1.

i. If the renewal application is sent during the first year of the biennial period, the applicant shall submit the renewal fee as set forth at N.J.A.C. 13:30-8.1.

ii. If the renewal application is sent during the second year of the biennial period, the applicant shall submit one-half of the renewal fee as set forth at N.J.A.C. 13:30-8.1; and

4. Evidence of having completed all continuing education credits that were required to be completed during the biennial period immediately prior to the renewal period for which reactivation is sought, consistent with the requirements set forth at N.J.A.C. 13:30-5.1, 5.2, and 5.3, as applicable.

i. An applicant who holds a valid, current license or registration in good standing issued by another state to engage in the practice of dentistry, dental hygiene, dental assisting, or dental assisting in orthodontics, as applicable, and submits proof of having satisfied that state's continuing education requirements for that license or registration, shall be deemed to have satisfied the requirements of this paragraph. If the other state does not have any continuing education requirements, the requirements of this paragraph shall apply.

ii. To the extent that specific courses are required to satisfy the continuing education requirement for, or are required to have been satisfied prior to, the biennial period for which reactivation is sought, the Board will allow applicants to take the courses within 12 months following reactivation.

(b) If a Board review of an application establishes a basis for concluding that there may be practice deficiencies in need of remediation prior to reactivation, the Board may require the applicant to submit to, and successfully pass, an examination or an assessment of skills, a refresher course, or other requirements as determined by the Board prior to reactivation of the license or registration. If that examination or assessment identifies deficiencies or educational needs, the Board may require the applicant, as a condition of reactivation of licensure or registration, to take, and successfully complete, any education or training or to submit to any supervision, monitoring, or limitations as the Board determines is necessary to ensure that the applicant practices with reasonable skill and safety. The Board, in its discretion, may restore the license or registration subject to the applicant's completion of the training within a period of time prescribed by the Board following the restoration of the license or registration. In making its determination whether there are practice deficiencies requiring remediation, the Board shall consider the following non-exhaustive factors:

1. Length of time license or registration was inactive;

2. Employment history;

3. Professional history;

4. Disciplinary history and any action taken against the applicant's license or registration by any licensing board;

5. Actions affecting the applicant's privileges taken by any institution, organization, or employer related to the practice of dentistry, dental hygiene, dental assisting, or dental assisting in orthodontics, as applicable, or other professional or occupational

practice in New Jersey, any other state, the District of Columbia, or in any other jurisdiction;

6. Pending proceedings against a professional or occupational license or registration issued to the licensee or registrant by a professional board in New Jersey, any other state, the District of Columbia, or in any other jurisdiction; and

7. Civil litigation related to the practice of dentistry, dental hygiene, or dental assisting, as applicable, or other professional or occupational [page=640] practice in New Jersey, any other state, the District of Columbia, or in any other jurisdiction.

13:30-8.6B License and registration reinstatement

(a) A licensee or registrant who has had his or her license or registration suspended pursuant to N.J.A.C. 13:30-8.6(e) may apply to the Board for reinstatement. A licensee or registrant applying for reinstatement shall submit:

1. A reinstatement application;

2. A certification of employment listing each job held during the period of suspended license or registration, which includes the name, address, and telephone number of each employer;

3. The renewal fee for the biennial period for which reinstatement is sought;

4. The past due renewal fee for the biennial period immediately preceding the renewal period for which reinstatement is sought;

5. The reinstatement fee set forth at N.J.A.C. 13:30-8.1; and

6. Evidence of having completed all continuing education credits that were required to be completed during the biennial period immediately prior to the renewal period for which reinstatement is sought, consistent with the requirements set forth at N.J.A.C. 13:30-5.1, 5.2, and 5.3, as applicable.

i. An applicant who holds a valid, current license or registration in good standing issued by another state to engage in the practice of dentistry, dental hygiene, dental assisting, or dental assisting in orthodontics, as applicable, and submits proof of having satisfied that state's continuing education requirements for that license or registration, shall be deemed to have satisfied the requirements of this paragraph. If the other state does not have any continuing education requirements, the requirements of this paragraph shall apply.

ii. To the extent that specific courses are required to satisfy the continuing education requirement for, or are required to have been satisfied prior to, the biennial period for which reinstatement is sought, the Board will allow applicants to take the courses within 12 months following reinstatement.

(b) If a Board review of an application establishes a basis for concluding that there may be practice deficiencies in need of remediation prior to reinstatement, the Board may require the applicant to submit to, and successfully pass, an examination or an assessment of skills, a refresher course, or other requirements as determined by the Board prior to reinstatement of the license or registration. If that examination or assessment identifies deficiencies or educational needs, the Board may require the applicant, as a condition of reinstatement of licensure, to take, and successfully complete, any education or training or to submit to any supervision, monitoring, or limitations as the Board determines is necessary to assure that the applicant practices with reasonable skill and safety. The Board, in its discretion, may restore the license or registration subject to the applicant's completion of the training within a period of time prescribed by the Board following the restoration of the license or registration. In making its determination whether there are practice deficiencies requiring remediation, the Board shall consider the following non-exhaustive factors:

1. Length of time license or registration was suspended;

2. Employment history;

3. Professional history;

4. Disciplinary history and any action taken against the applicant's license by any licensing board;

5. Actions affecting the applicant's privileges taken by any institution, organization, or employer related to the practice of dentistry, dental hygiene, dental assisting, or dental assisting in orthodontics, as applicable, or other professional or occupational practice in New Jersey, any other state, the District of Columbia, or in any other jurisdiction;

6. Pending proceedings against a professional or occupational license or registration issued to the licensee or registrant by a professional board in New Jersey, any other state, the District of Columbia, or in any other jurisdiction; and

7. Civil litigation related to the practice of dentistry, dental hygiene, dental assisting, or dental assisting in orthodontics, as

applicable, or other professional or occupational practice in New Jersey, any other state, the District of Columbia, or in any other jurisdiction.

13:30-8.7 Patient records

(a) A contemporaneous, permanent patient record shall be prepared and maintained by a licensee for each person seeking or receiving dental services, regardless of whether any treatment is actually rendered or whether any fee is charged. Licensees shall also maintain records relating to charges made to patients and third-party carriers for professional services. All treatment records, bills, and claim forms shall accurately reflect the treatment or services rendered. Such records shall include, at a minimum:

1.-3. (No change.)

4. A diagnosis and a treatment plan *[signed by the patient]*, which shall also include the material treatment risks and clinically acceptable alternatives, and costs relative to the treatment that is recommended and/or rendered*[. Any significant changes to the treatment plan requires the patient to sign the revised treatment plan]*;

5.-14. (No change.)

(b) (No change.)

(c) A patient record may be prepared and maintained on a personal or other computer provided that the licensee complies with all of the following requirements:

1.-4. (No change.)

5. The licensee shall prepare a back-up of all computerized patient records at least quarterly, except that if a licensee changes computer systems or software programs, the licensee shall prepare a back-up as of the last date when the system to be replaced shall be used.

i.-iii. (No change.)

iv. The licensee shall maintain and store the fourth quarter (annual) back-up offsite;

6. The licensee shall provide to the Board upon request any back-up data maintained off premises, together with the following information:

i.-iii. (No change.)

iv. The name of a contact person at the practice management company, if any, that provides technical support for the licensee's computer system; and

7. Electronic records shall comply with the Federal Health Insurance Portability and Accountability Act of 1996 and the Federal health privacy rule set forth at 45 CFR Parts 160 and 164.

(d) Patient records, including all radiographs, shall be maintained for at least seven years from the date of the last entry, except that diagnostic and study models used for definitive treatment shall be maintained for at least three years from the date the model is made.

(e)-(i) (No change.)

13:30-8.8 Reporting of incidents or deaths

(a) All licensees shall report to the State Board of Dentistry within seven days, in writing, on a form supplied by the Board and available on the Board's website at www.njconsumeraffairs.gov/den, any incident occurring in a dental office, clinic, or any other dental facility after dental treatment has been initiated that requires the removal of a patient to a hospital for observation or treatment.

(b) All licensees shall report to the Board within seven days, in writing, on a form supplied by the Board and available on the Board's website at www.njconsumeraffairs.gov/den, any death, which may be related to dental treatment, whether or not the death occurred in a dental office, clinic, or other dental facility.

13:30-8.9 Display of names; identifying badges

(a) Every facility offering dental care to the public shall legibly display on all exterior signs or other means of exterior display, the names of the licensees who are *[the owners]* ***responsible for the administration*** of the facility. A dental facility may display on exterior signs or other means of exterior display, the names of licensees associated with the facility.

(b) (No change.)

(c) Every dental care facility engaged in providing dental care shall conspicuously display in its office, the names of the owners associated with the facility.

[(c)] ***(d)*** (No change in text.)

13:30-8.10 Third-party payor records

(a) (No change.)

[page=641] (b) No licensee shall submit to a third-party payor any claim, bill, or governmental assistance claim that contains any of the following:

1.-2. (No change.)

3. Any service or procedure, which cannot be justified by the licensee as necessary, proper, and/or beneficial;

4.-5. (No change.)

(c) (No change.)

(d) The accuracy of all information contained in written or electronic submissions to a third-party payor including predeterminations, claims, bills, or governmental assistance claims, shall be the personal responsibility of the licensee whose name, license number, or signature appears on the signature line of the claim. In the case of electronic claims, the licensee identified as the provider shall be held responsible for the accuracy of the information whether or not the licensee actually completed the claim. The Board shall presume that the licensee identified on the claim reviewed its contents and approved its submission.

1.-2. (No change.)

(e) All third-party payor records shall be maintained pursuant to the provisions of N.J.A.C. 13:30-8.7 or be readily retrievable.

13:30-8.12A Notification of conviction, arrest, or actions affecting privileges

A licensee or registrant shall notify the Board in writing within 30 days of receiving a summons; being arrested or taken into custody; being indicted, tried, charged with, or admitted into pre-trial intervention (P.T.I.); plead guilty to any violation of law, ordinance, felony, misdemeanor, or disorderedly persons offense in this State or any other state; being disciplined or denied a dental license or any other professional license; or having a professional license or certificate of any type suspended, revoked, or surrendered. Parking or speeding violations need not be disclosed, but motor vehicle violations, such as driving while impaired or intoxicated, shall be disclosed.

13:30-8.26 Emergency protocol

(a) Each dental office, facility, dental clinic, or institution at which there is patient contact, at a minimum, shall:

1. (No change.)

2. Have equipment to maintain adult and pediatric airways, including:

i. A portable oxygen delivery system, including full face masks and a bag-valve-mask combination with appropriate connectors capable of delivering positive pressure and oxygen-enriched patient ventilation; and

ii. Positive pressure oxygen;

3. Have an automatic external defibrillator (AED);

4. Contain back-up, battery-operated equipment consisting of, at a minimum, lighting, a blood pressure monitoring device, and a pulse oximeter, which shall be readily accessible and properly operating; and

5. (No change in text.)