VIRGINIA BOARD OF DENTISTRY

AGENDAS

June 12-13, 2014

Department of Health Professions

Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center - Henrico, Virginia 23233

PAGE

June 12, 2014

8:00 a.m. **Formal Hearings**

June 13, 2014

Board Business

9:00 a.m. **Call to Order – Dr. Levin, President**

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- December 5, 2013 Business Meeting **P1-P7**
- March 6, 2014 Formal Hearing **P8-P9**
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- April 3, 2014 Telephone Conference Call **P18-P19**
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DHP Director's Report – Dr. Brown

Liaison/Committee Reports

- BHP – Dr. Levin
- AADB – Report on Mid-Year Meeting
  - Dr. Levin's report **P30-P38**
  - Ms. Palmatier's report **P39-P46**
- ADEX – Dr. Rolon & Dr. Rizkalla
  - 2012-2013 Annual Report **P47-P77**
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- SRTA – Dr. Watkins & Ms. Swecker
- Regulatory-Legislative Committee – Dr. Levin
  - May 2, 2014 Draft Minutes **P79-P83**

Legislation and Regulation – Ms. Yeatts

- Status Report on Regulatory Actions **P84**
- Draft Legislation on Fee Spitting **P85-P106**
- Adoption of Guidance Document
  - Implementation of Periodic Office Inspections **P107-P109**

Board Discussion/Action

- Review of Public Comment Topics
- Purpose and Development Process for Guidance Documents – Ms. Reen **P110**
- Draft Guideline for Conscious/Moderate Sedation **P111-P114**
- Draft on Record Keeping for Endodontic Root Canal Treatment **P115-P123**
- Billing for a Periodic Exam Performed by a Dental Hygienist – Dr. Watkins **P124-P131**
- Changing the Education Requirement for Dental Licensure – Dr. Wyman **P132-P133**
- Electronic Dental Records – Dr. Rizkalla **P134**

Disciplinary Activity Report – Ms. Palmatier **P135-137**

Executive Director's Report/Business – Ms. Reen

- Revised Inspection Form for Permit Holder Office Inspections **P138-P143**
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- Board Staffing
- 2015 Proposed Calendar **P144**

1:30 p.m. **Formal Hearing**

Virginia Board Business Meeting Materials

On

June 13, 2014

Part 1

P1-P83

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES
DECEMBER 5, 2013

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 1:37 p.m. on December 5, 2013, in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Jeffrey Levin, D.D.S., President

BOARD MEMBERS PRESENT:

Charles E. Gaskins, III, D.D.S.
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.D.S.

BOARD MEMBERS ABSENT:

Surya P. Dhakar, D.D.S.
Myra Howard, Citizen Member

STAFF PRESENT:

Sandra K. Reen, Executive Director for the Board
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

OTHERS PRESENT: None

ESTABLISHMENT OF A QUORUM: With eight members of the Board present, a quorum was established.

PUBLIC COMMENT: Dr. Mitchell J. Buzkin of Woodbridge, VA stated that his letter was on the agenda for Board consideration.

APPROVAL OF MINUTES: Dr. Levin asked if the Board members had reviewed the minutes listed on the agenda. Dr. Watkins moved to accept the minutes in a block. The motion was seconded and carried.

DHP DIRECTOR'S REPORT: Dr. Levin noted that Dr. Reynolds-Cane was not available to attend the meeting.

VIRGINIA'S DENTISTRY AND DENTAL HYGIENIST WORKFORCE 2013:

Mr. Justin Crow, Virginia Healthcare Workforce Data Center (HWDC) Policy & Planning Specialist, stated that the two reports represented the latest findings from the surveys completed by licensees who renewed their licenses online by March 31, 2013. He then reported the following:

- Response rate – 78% of dentists and 88% of dental hygienists
- Full-time equivalency units (working 40 hours per week for 50 weeks with 2 weeks off) – 4,490 dentists and 3,062 dental hygienists
- Job satisfaction – 96% of dentists and 92% of dental hygienists are satisfied with their job
- Median age – 50 for dentists and 44 for dental hygienists
- Completed undergraduate program in VA – 41% of dentists and 62% of dental hygienists

Mr. Crow asked Board members for their feedback by December 13, 2013, so the reports might be posted to the DHP website. He then answered Board members' questions.

Dr. Levin asked if new graduates are tracked. Mr. Crow said no because the reports were collected at renewals.

Ms. Reen asked how this data is being used. Mr. Crow replied that it is used by healthcare decision makers, hospitals and academic institutions to measure the healthcare workforce in Virginia.

Dr. Levin asked how new graduates can be helped by HWDC. Mr. Crow stated that graduates can contact HWDC for assistance. He added that HWDC works with the Healthcare Workforce Development Authority, which works to identify, recruit and retain health professionals in Virginia's workforce.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Levin stated that he had nothing to report since the meeting was cancelled.

AADB. Ms. Swain stated that she and Ms. Reen attended the Annual meeting in October, 2013, and her report was provided in the agenda package.

ADEX. Dr. Rolon stated that she attended the ADEX House of Representatives meeting, and that her report was provided on lavender paper.

Dr. Watkins stated that he attended the ADEX Dental Examination Committee meeting in November, 2013. He added that CITA has joined ADEX, which makes the ADEX examination acceptable in 45 jurisdictions.

SRTA. Dr. Watkins stated that the SRTA 2014 exam schedule has not been sent to him yet, but he will send the first draft out to examiners for review.

Ms. Swecker reported that there is no major change in the dental hygiene exam. She added that the ADEX exam will be administered to dental hygienists beginning in 2015.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported the following:

- Sedation and Anesthesia permits for dentists - The emergency regulations will expire on March 15, 2014. The public comment period on the final regulations ends at 5 pm on December 6, 2013. The Executive Committee will meet on January 10, 2014, to review any additional comments and to adopt the final regulations.
- Periodic Review – The proposed regulations to establish four chapters have been approved by the Governor. The public comment period will end on January 11, 2014, and no comment has been received to date.
- Correction of renewal deadline for faculty licenses – §54.1-2713.D of the Code relating to faculty licenses was amended in 2012. As a result, the Regulations Governing Dental Practice were amended by the Board at its September, 2013 meeting to conform to the statute. The correction has been at the Attorney General's Office for review for 68 days.

BOARD DISCUSSION/ACTION:

Review of Public Comment Topics.

Letter from Dr. Bukzin – Ms. Reen stated that the letter from Dr. Buzkin expresses his concern about fraud and the work of the Board. She asked for Board guidance on the response to be given. Dr. Levin stated that complaints need to be made to the Board for investigation. No action was taken.

Education Requirement for Licensure – Dr. Wyman said that after reviewing the information collected by staff, he is withdrawing his request for discussion. Ms. Reen noted that the Board has licensed 214 dentists with only advance education since 2005, and only 1 of these licensees has been disciplined by the Board.

Guidance Document (GD) on Advertising – Ms. Reen noted that this item was discussed by the Regulatory-Legislative Committee earlier today. She added that the Committee recommended dropping the Guidance Document from the Board's list of pending actions. Dr. Watkins moved to accept the recommendation. The motion was seconded and passed.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported that for the first quarter of FY2014, the Board received a total of 96 cases which included 63 patient care cases and closed a total of 82 patient care cases for 130% clearance rate. She added that 74% of the patient care cases were closed within 250 days and the Board met the clearance rate goals for the Agency's Key Performance Measures for the first quarter of FY2014.

She noted that the Board summarily suspended the license of 2 dental hygienists and 1 dentist between August 22, 2013, and November 25, 2013.

She stated that staff is requesting policy guidance on monetary penalties in response to a recent trend occurring in informal conferences. Guidance is needed so that the sanction for similar violations is consistent across all committees and in Pre-Hearing Consent Orders being offered. She reported that the precedent set by the Board has been to use $1,000 as the standard monetary penalty per violation. She added that probable cause reviewers and special conference committees can and should consider aggravating and/or mitigating circumstances as a reason for any departure from this standard. By consensus, the Board agreed to use $1,000 as the standard monetary penalty per violation.

Ms. Palmatier thanked the Board for their continued hard work on getting the backlog of cases resolved. She added that one issue that seems to be taking up some time is the back and forth communication between reviewers and staff with regards to the violations to be alleged. She provided a copy of a completed probable cause review form as a good example of a clear statement of a board member's case review decision.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Report on the AADA Annual Meeting – Ms. Reen reported that the AADA meeting was very productive. She added that she brought back useful information that staff will be discussing in the coming months.

Retirement Recognition - Ms. Reen reported that Mr. Howard Casway is retiring effective January 1, 2014. She noted that he has served as Board Counsel since 1983. Dr. Watkins agreed to work with Ms. Reen on reviewing Mr. Casway's history of service. She said that the Attorney General's office is planning to have a retirement party for Mr. Casway in 2014. She added that he was unable to join the Board for lunch today and suggested inviting him to lunch at the March, 2014 meeting. After discussion, the Board decided to prepare a "Memory Book" for Mr. Casway, and to invite him to the Board's March meeting.

Electronic Recordkeeping – Dr. Gaskins raised a concern, as addressed in Ms. Swain's previously cited AADB meeting report, about authenticating electronic patient records, which might easily be altered. Following discussion, Ms. Reen said she will obtain the presentation from the AADB, and she will share it with the Enforcement division for consideration in investigations.

Teledentistry – Ms. Swecker noted that teledentistry, as addressed in Ms. Swain's AADB meeting report, is on the rise. She suggested that the Board look at this matter and determine its position. After discussion, Ms. Swecker moved to investigate permitting the practice of teledentistry within Virginia by addressing a definition, guidelines, and scope of practice. The motion was seconded and passed. Ms. Reen asked if the Board wanted to assign this to the Regulatory-Legislative Committee. All agreed.

CASE RECOMMENDATIONS:

Case # 150265:

Closed Meeting:

Ms. Swain moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of case #150265. Additionally, it was moved that Board staff, Sandra Reen, Ms. Palmatier, and Huong Vu attend the closed meeting because their presence in the closed meeting was deemed

necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

Ms. Swain moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to §2.2-3712(D) of the Code.

DECISION:

Dr. Watkins moved to offer a Consent Order for voluntary surrender for permanent suspension in lieu of proceeding with the scheduled formal hearing. The motion was seconded and passed.

Case# 151455:

The Board received information from Mr. Halbleib on case #151455 in order to determine if the Respondent is unable to practice dentistry in a safe and competent manner due to alcohol abuse.

Closed Meeting:

Ms. Swain moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of case #151455. Additionally, it was moved that Board staff, Sandra Reen, Ms. Palmatier, and Huong Vu and Board Counsel Charis Mitchell attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed .

Reconvene:

Ms. Swain moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

DECISION:

Dr. Wyman moved that the Board summarily suspend the license of the respondent in case #151455 to practice dentistry in the Commonwealth of Virginia due to alcohol abuse, and schedule the respondent for a formal hearing. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 3:45 p.m.

Jeffrey Levin, D.D.S., President	Sandra K. Reen, Executive Director
Date	Date

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
March 6, 2014

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 9:04 a.m., on March 6, 2014 in Board Room 3, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Jeffrey Levin, D.D.S., President

MEMBERS PRESENT: Charles E. Gaskins, III, D.D.S.
A Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBER ABSENT: Surya P. Dhakar, D.D.S
Myra Howard, Citizen Member

STAFF PRESENT: Sandra K. Reen., Executive Director
Huong Q. Vu, Operations Manager

COUNSEL PRESENT: Erin L. Barrett, Assistant Attorney General

OTHERS PRESENT: Wayne Halbleib, Senior Assistant Attorney General
Shevaun Roukous, Adjudication Specialist
Beth Aliff, Court Reporter, Farnworth & Taylor Reporting.

ESTABLISHMENT OF A QUORUM: With eight members present, a quorum was established.

Christopher A. Dail, D.D.S.
Case No.: 151235

Dr. Dail appeared without legal counsel in accordance with a Notice of the Board dated October 3, 2013.

Mr. Halbleib reported that Dr. Dail contacted him and said he does not contest the allegations stated in the notice then asked about entering into a consent order. Mr Halbleib then presented the consent order he prepared for the Board's consideration.

Dr. Dail said that he made bad decisions in treating himself with narcotic medicine and has no excuse for his action. He stated that he tried to enroll into the Health Practitioners' Monitoring

Program (HPMP) in November 2013 but was denied because his license was suspended. He said he wishes to participate in HPMP and will do whatever the Board asks of him.

Closed Meeting: Ms. Swain moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia for the purpose of deliberation to reach a decision on the proposed consent order affecting the license of Christopher A. Dail, DDS. Additionally, she moved that Board staff, Ms. Reen, Ms. Vu, and Board counsel, Ms. Barrett attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Ms. Swain moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision: Dr. Gaskins moved to accept the proposed consent order as amended. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 11:41 a.m.

Jeffrey Levin, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES
March 7, 2014

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:03 a.m. on March 7, 2014, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Jeffrey Levin, D.D.S., President

BOARD MEMBERS PRESENT:

Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.D.S.

BOARD MEMBERS ABSENT: Myra Howard, Citizen Member

STAFF PRESENT:

Sandra K. Reen, Executive Director for the Board
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

OTHERS PRESENT:

David E. Brown, D.C., DHP Director
Allyson Tysinger, Senior Assistant Attorney General

ESTABLISHMENT OF A QUORUM: With nine members of the Board present, a quorum was established.

PUBLIC COMMENT: None.

APPROVAL OF MINUTES: Dr. Levin asked for approval of the minutes as listed on the agenda.

Ms. Swain asked that the December 5, 2013 minutes be amended to include the topics prioritized for action. Ms. Reen asked that these minutes be addressed at the June meeting. All agreed.

The Board's December 6, 2013, January 10, 2014 and January 24, 2014 minutes were approved as published and circulated.

DHP DIRECTOR'S REPORT:

Dr. Levin welcomed and introduced Dr. David E. Brown, DHP's new director. Dr. Brown said he looks forward to working with the Board and noted that he is a former member of the Board of Medicine.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Levin said he did not attend the last meeting and will report at the next meeting.

AADB. Dr. Levin stated that he will attend the AADB Mid-Year meeting in April.

ADEX. Dr. Rolon highlighted changes made to the dental and dental hygiene exams for 2014.

Dr. Rizkalla stated that he will be representing the Board on the Dental Exam Committee at the ADEX Annual meeting in November, 2014.

SRTA. Dr. Watkins said the transition to the ADEX exam is going well and added that SRTA no longer has a separate Exam Committee.

Ms. Swecker reported that only minor changes were made in the dental hygiene exam. She added that the ADEX exam will be administered to dental hygienists beginning in 2015.

SCDDE. Dr. Levin stated that he and Ms. Reen presented at the annual meeting which was hosted by VCU this year.

LEGISLATION AND REGULATIONS:

Report of the 2014 General Assembly. Ms. Yeatts reported that:

- SB647 which directs DMAS to create and to report on a teledentistry pilot program to provide dental services to eligible school-age children has been continued to the 2015 session of the General Assembly.
- HB505 has a delayed effective date of January 1, 2015 to enforce penalties for distributing or selling Dextromethorphan (cough suppressant found in much over-the-counter medication) to a minor.

Status Report on Regulatory Actions. Ms. Yeatts reported the following:

- Sedation and Anesthesia permits for dentists - The emergency regulations expire on March 15, 2014. The final

regulations are still under review by the Secretary of Health and Human Resources. The Board will not be able to issue permits or enforce the regulations after March 15, 2014, until such time as the final regulations are effective.

- Periodic Review – The Board will consider adoption of proposed final regulations today.
- Correction of renewal deadline for faculty licenses –The amendment changing the renewal date to June 30 as required by statute became effective on February 12, 2014.

Adopt Proposed Final Regulations. Dr. Levin credited Ms. Reen for her efforts in reorganizing the regulations into four chapters then asked Ms. Yeatts to lead discussion.

Chapter 15 Regulations Governing the Disciplinary Process
Ms. Yeatts said no changes have been made to this chapter. Dr. Gaskins moved to adopt the proposed Chapter 15. The motion was seconded and passed.

Athermal Laser References. Ms. Yeatts reported that staff was unable to find a definition of the term "athermal laser" applicable to dentistry. She proposed defining the term "non-surgical laser" and amending sections 18VAC60-21-140(A)(1) and 18VAC60-25-40(C)(1) to use this term. Ms. Swecker so moved. The motion was seconded and passed.

Basic CPR vs. Basic CPR for Health Care Professionals. Ms. Yeatts stated that staff obtained information on the courses offered by three continuing education providers for review and a decision on whether to amend sections 18VAC60-21-250(A)(2) and 18VAC60-25-190(A)(1). Dr. Rizkalla moved to use the phrase "CPR for Health Care Professionals." The motion was seconded and passed.

Ms. Swecker asked if training in the use of epinephrine auto-injectors and asthma inhalers should be added. Dr. Levin suggested addressing this in a future regulatory action. All agreed.

Chapter 21 Regulations Governing the Practice of Dentistry
Ms. Yeatts said the adopted Sedation/Anesthesia regulations are included in this chapter then led the review.

18VAC60-21-80.D – It was suggested that the word "*broadcast*" from the heading be deleted. All agreed.

18VAC60-21-110 – Ms. Swecker asked if free clinics include nursing homes and assisting living facilities. Ms. Yeatts said that the term "free clinics" is defined in the Code. Ms. Swecker asked that

treatment in nursing homes and assisted living facilities be added. Ms. Yeatts said this would be a major change requiring another public comment period on this regulatory package and suggested addressing this in a future regulatory action. All agreed.

18VAC60-21-140 – the term "*athermal lasers*" was changed to "*non-surgical laser.*"

18VAC60-21-250.C(15) – the "*Council of Interstate Testing Agencies (CITA)*" was added.

Dr. Watkins moved to adopt Chapter 21 as amended. The motion was seconded and passed.

Chapter 25 Regulations Governing the Practice of Dental Hygiene.

18VAC60-25-40.C(1) – the term "*athermal lasers*" was changed to "*non-surgical laser.*"

18VAC60-25-190.C(15) – the "*Council of Interstate Testing Agencies (CITA)*" was added.

Dr. Gaskins moved to adopt Chapter 25 as amended. The motion was seconded and passed.

Chapter 30 Regulations Governing the Practice of Dental Assistants

Dr. Rizkalla moved to adopt Chapter 30 as presented. The motion was seconded and passed.

Ms. Tysinger asked the Board to consider 18VAC 60-21-80.G(1) on publishing an advertisement. She asked about amending this section to change the language from "causes" to "would cause" an ordinarily prudent person to misunderstand or be deceived. Ms. Yeatts noted that "causes" is not new language and Ms. Reen said it was adopted some time ago based on the advice of Board Counsel. Ms. Tysinger said she would research this.

Dr. Wyman asked about notifying licensees of the changes when these chapters are effective. Ms. Reen said licensees are responsible for and attest to keeping current with the laws and regulations. She added that work on this regulatory package has been addressed in BRIEFS which is sent out every six months via e-mail.

Dr. Wyman moved to notify licensees by e-mail when the new regulations go into effect so they know to read them. The motion was seconded and passed.

Ms. Reen suggested sending the notice when the regulations are scheduled for publication. All agreed.

Ms. Swecker asked for reconsideration of 18 VAC 60-20-110 to address vulnerable populations unable to travel to a dental office. No action was taken.

BOARD DISCUSSION/ACTION: **Review of Public Comment Topics.**

Letter from Dr. Sherwin – Dr. Sherwin's request for a more receptive atmosphere during the Board's public comment period was reviewed and accepted as information.

Letter from Dr. Bennett – Dr. Bennett's request for the Board to work with the VDA and the VCU School of Dentistry to promote professional behavior was reviewed and accepted as information.

Guideline for Conscious/Moderate Sedation – Dr. Levin said he developed this draft to address implementation of the regulations on sedation. Ms. Tysinger said a legal review is needed and suggested deferring discussion to the June meeting. All agreed.

Review of Parliamentary Use – Dr. Gaskins commented that the Board might benefit from following some basic parliamentary procedures. He then addressed several procedures for the conduct of meetings and management of motions.

Review of Freedom of Information Act – Dr. Gaskins stated that Board members need to be aware of the requirements of this law then reviewed sections addressing meetings and minutes.

ADA CERP 2013 Annual Report – Dr. Levin stated that this was provided as information only.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported on the Board's disciplinary case statistics, noting that the Board received 407 cases and closed 409 cases in 2013. She added that the Board received a total of 63 and closed total of 80 cases for a 127% clearance rate in the second quarter of FY2014 and noted that two dentists were suspended in the last three months.

Ms. Palmatier stated that the Credentials Committee and staff are requesting guidance on an argument made by an applicant for licensure by credentials that he only needs to show he completed dental training at a university or college accredited by CODA rather than show that he completed a CODA accredited program.

She said 18VAC60-20-71(2) on licensure by credentials requires an applicant to "*Be a graduate of a dental program, school or college, or dental department of a university or college currently accredited by the Commission on Dental Accreditation of the American Dental Association.*" In contrast, 18VAC60-20-60 on educational requirements requires an applicant to "*...be a graduate and a holder of a diploma or a certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association, which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program in any other specialty.*"

She asked the Board for its interpretation of 18VAC60-20-70(2). Ms. Reen noted that the dental application instructions are provided for review.

After discussion, the Board agreed that the intent of the two regulations is the same; that an applicant must have completed a CODA accredited program, as stated in the application instructions and as addressed in the proposed Chapter 21.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Board Counsel – Ms. Reen reported James Rutkowski will begin serving as Board Counsel on Monday, March 10, 2014. She added that he worked in the Administrative Proceedings Division before moving to the Office of the Attorney General.

Board BRIEFS – In response to concerns reported by Board members, Ms. Reen explained that the format for BRIEFS was established to facilitate a regular flow of information from the Board to its licensees. She said the format is to highlight the work of the Board and provide links to additional information. She added it is not possible to address every subject discussed and accomplish a regular flow of information. She added that the Board could consider a different format.

December 5, 2013 business meeting minutes – Ms. Reen stated that she talked with Ms. Swain about her request to amend these minutes to address the prioritization of issues adopted. She said

the prioritization of issues was addressed by the Regulatory-Legislative Committee which also met on December 5, 2013. She added that the Committee minutes do include this discussion and that the Board's meeting minutes will be included in the June agenda package for adoption without any changes.

Public Comment Script – Ms. Reen proposed that she develop a script to be read prior to the public comment period so that the public will understand the that the Board cannot engage in a discussion. Ms. Tysinger said she would provide examples of scripts. All agreed.

Discussion of Public Comment – Ms. Reen explained that the only opportunity the Board has to address the issues and concerns raised in public comment is to discuss it when it comes up on the agenda.

CASE RECOMMENDATIONS:

Dr. Levin asked a dental applicant to address his application before the Board entered into closed session. After hearing from the applicant, Dr. Levin explained the Board would report its decision on the applicant's case immediately following the closed session.

Case # 153117:

Closed Meeting: Ms. Swain moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of case #153117. Additionally, it was moved that Board staff, Ms. Reen, and Ms. Palmatier attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Ms. Swain moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to §2.2-3712(D) of the Code.

DECISION: Dr. Wyman moved to adopt the recommended decision of the Credentials Committee. The motion was seconded and passed.

Case # 152164, 153268 154322:

Closed Meeting: Ms. Swain moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of cases #152164, 153268 and 154322. Additionally, it was moved that Board staff, Ms. Reen, and Ms. Palmatier attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Ms. Swain moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

DECISION: Dr. Watkins moved to adopt the recommended decisions of the Credentials Committee. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 12:15 p.m.

Jeffrey Levin, D.D.S., President	Sandra K. Reen, Executive Director
Date	Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION - TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:19 p.m., on April 3, 2014, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Jeffrey Levin, D.D.S., President

MEMBERS PRESENT:
Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
Myra Howard
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT: Melanie C. Swain, R.D.H.

QUORUM: With nine members present, a quorum was established.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Shevaun Roukous, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General
Corie E. Tillman Wolf, Assistant Attorney General

Derrick Broadaway, D.D.S.
Case Nos.: 147781, 147700, 147749, 147816, 147322, 147846, 148561, 148408, and 152429

The Board received information from Ms. Wolf in order to determine if, based on Dr. Broadaway's Board history and pending cases, his treatment of patients fails to meet the standard of care in the practice of dentistry and constitutes a substantial danger to public health and safety.

Closed Meeting: Dr. Gaskins moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Derrick Broadaway. Additionally, Dr. Gaskins moved that Ms. Reen, Mr. Rutkowski, and Ms. Lee attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Gaskins moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

DECISION: Dr. Gaskins moved that the Board summarily suspend Dr. Broadaway's license to practice dentistry in the Commonwealth of Virginia because his treatment of patients fails to meet the standard of care in the practice of dentistry, and schedule him for a formal hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 5:40 p.m.

Jeffrey Levin, D.D.S., Chair	Sandra K. Reen, Executive Director
Date	Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION - TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:17 p.m., on April 23, 2014, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Jeffrey Levin, D.D.S., President

MEMBERS PRESENT:
Charles E. Gaskins, III, D.D.S.
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
Surya P. Dhakar, D.D.S.
Myra Howard

QUORUM: With eight members present, a quorum was established.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Gerald A. Milsky, Adjudication Specialist
Donna M. Lee, Discipline Case Manager

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General
Corie E. Tillman Wolf, Assistant Attorney General

William Heath Allen, Jr., D.D.S.
Case No.: 153446

The Board received information from Ms. Wolf in order to determine if Dr. Allen's practice of dentistry constitutes a substantial danger to public health and safety. Ms. Wolf reviewed the case and responded to questions.

Closed Meeting: Ms. Swain moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of William Heath Allen, Jr. Additionally, Ms. Swain moved that Ms. Reen, Mr. Rutkowski, and Ms. Lee attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene:

Ms. Swain moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

DECISION: Dr. Gaskins moved that the Board find Dr. Allen practiced in a manner to cause patient harm and that his license to practice dentistry shall be summarily restricted from administering Septocaine; and that prior to

administration of any local anesthesia, he must take and record the weight of the patient to be used in computing the maximum safe and appropriate dosage for the patient. Dr. Gaskins further moved that Dr. Allen be scheduled for an informal conference as soon as possible. Following a second and discussion, a roll call vote was taken. The motions passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 6:28 p.m.

Jeffrey Levin, D.D.S., Chair	Sandra K. Reen, Executive Director
Date	Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 11:35 a.m., on May 9, 2014, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Board Room 4, 9960 Mayland Drive, Henrico, VA 23233.

FIRST PRESENTATION: 11:35 a.m.

PRESIDING: Melanie C. Swain, R.D.H., Vice-President

MEMBERS PRESENT:
Charles E. Gaskins, III, D.D.S.
Myra Howard
Evelyn M. Rolon, D.M.D.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
Surya P. Dhakar, D.D.S.
Jeffrey Levin, D.D.S.
A. Rizkalla, D.D.S.
Tammy K. Swecker, R.D.H.

QUORUM: With six members present, a quorum was established.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Gerald A. Milsky, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General
Wayne T. Halbleib, Senior Assistant Attorney General

Tracy E. Spraker, R.D.H.
Case No.: 155393

The Board received information from Mr. Halbleib in order to determine if Ms. Spraker's impairment from substance abuse constitutes a substantial danger to public health and safety. Mr. Halbleib reviewed the case and responded to questions.

Closed Meeting: Dr. Gaskins moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Tracy E. Spraker. Additionally, Dr. Gaskins moved that Ms. Reen, Mr. Rutkowski, and Ms. Lee attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Gaskins moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

DECISION: Dr. Watkins moved that the Board summarily suspend Ms. Spraker's license to practice dental hygiene in the Commonwealth of Virginia in that she is unable to practice dental hygiene safely due to impairment resulting from substance abuse, and schedule her for a formal hearing; also offer a consent order for the indefinite suspension of her license to practice dental hygiene for not less than two years in lieu of proceeding with a formal hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

SECOND PRESENTATION: 11:56 a.m.

PRESIDING: Melanie C. Swain, R.D.H., Vice-President

MEMBERS PRESENT:
Charles E. Gaskins, III, D.D.S.
Myra Howard
Evelyn M. Rolon, D.M.D.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
Surya P. Dhakar, D.D.S.
Jeffrey Levin, D.D.S.
A. Rizkalla, D.D.S.
Tammy K. Swecker, R.D.H.

QUORUM: With six members present, a quorum was established.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Gerald A. Milsky, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General
James E. Schliessmann, Assistant Attorney General

Kym Johnson-Virgil, D.D.S.
Case Nos.: 153370, 154963, 155254, and 155255

The Board received information from Mr. Schliessmann in order to determine if Dr. Johnson-Virgil's practice of dentistry and impairment from physical illness constitute a substantial danger to public health and safety. Mr. Schleissmann reviewed the case and responded to questions.

Closed Meeting: Dr. Gaskins moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Kym Johnson-Virgil. Additionally, Dr. Gaskins moved that Ms. Reen, Mr. Rutkowski, and Ms. Lee attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Gaskins moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

DECISION: Dr. Gaskins moved that the Board summarily suspend Dr. Johnson-Virgil's right to renew her license to practice dentistry in the Commonwealth of Virginia in that her practice of dentistry and her impairment resulting from physical illness constitute a substantial danger to public health and safety, and schedule her for a formal hearing; also offer a consent order for the indefinite suspension of the right to renew her license to practice dentistry for not less than two years in lieu of proceeding with a formal hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

THIRD PRESENTATION: 12:12 p.m.

PRESIDING: Melanie C. Swain, R.D.H., Vice-President

MEMBERS PRESENT:
Charles E. Gaskins, III, D.D.S.
Myra Howard
Evelyn M. Rolon, D.M.D.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
Surya P. Dhakar, D.D.S.
Jeffrey Levin, D.D.S.
A. Rizkalla, D.D.S.
Tammy K. Swecker, R.D.H.

QUORUM: With six members present, a quorum was established.

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General
James E. Schliessmann, Assistant Attorney General

JoAnne Cagwin, R.D.H.
Case No.: 154026

The Board received information from Mr. Schliessmann in order to determine if Ms. Cagwin's impairment from alcohol abuse and mental illness constitute a substantial danger to public health and safety. Mr. Schleissmann reviewed the case and responded to questions.

Closed Meeting: Dr. Gaskins moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of JoAnne Cagwin. Additionally, Dr. Gaskins moved that Ms. Reen, Mr. Rutkowski, and Ms. Lee attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Gaskins moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

DECISION: Dr. Wyman moved that the Board summarily suspend Ms. Cagwin's right to renew her license to practice dental hygiene in the Commonwealth of Virginia in that she is unable to practice dental hygiene safely due to impairment resulting from alcohol abuse and mental illness, and schedule her for a formal hearing; also offer a consent order for the indefinite suspension of the right to renew her license to practice dental hygiene for not less than two years in lieu of proceeding with a formal hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 12:22 p.m.

Melanie C. Swain, R.D.H., Chair	Sandra K. Reen, Executive Director
Date	Date

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
May 9, 2014

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 1:08 a.m., on May 9, 2014 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Melanie C. Swain, R.D.H.

MEMBERS PRESENT:
Charles E. Gaskins, III, D.D.S.
Surya P. Dhakar, D.D.S
Myra Howard, Citizen Member
Evelyn M. Rolon, D.M.D.
Bruce S. Wyman, D.M.D.

MEMBER ABSENT:
Jeffrey Levin, D.D.S., D.D.S.
A Rizkalla, D.D.S.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

STAFF PRESENT:
Sandra K. Reen., Executive Director
Huong Q. Vu, Operations Manager

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT:
Corie Wolf, Assistant Attorney General
Shevaun Roukous, Adjudication Specialist
Andrea Pegram, Court Reporter, Court Reporting Services, L.L.C.

ESTABLISHMENT OF A QUORUM: With six members present, a quorum was established.

Derrick M. Broadaway, D.D.S.
Case No.: 147322, 147700, 147781, 147816, 147846, 148408, 148561, and 152429

Dr. Broadaway appeared with Jeroyd W. Greene, III, Esquire in accordance with a Notice of the Board dated April 11, 2014. Mr. Green stated that he is not representing Dr. Broadaway but would be observing the proceedings.

Ms. Swain swore in the witnesses.

Following Ms. Wolf's opening statement, Ms. Swain admitted into evidence Commonwealth's exhibits 1 through 22.

Following Dr. Broadaway's opening statement, Ms. Swain admitted into evidence Respondent's exhibit A.

Testifying on behalf of the Commonwealth were the following:
In Person: John Turner, DHP Senior Investigator, Charlotte Hudson, DHP Senior Investigator, Dina Pearl, DDS, Patient A, Patient I, Patient K, and Henry M. Botuck, DDS.
By Phone: Daniel Jones, DDS, Richard Sweeney, DDS, Brian Szakaly, DDS, OMS, and Patient J.

Dr. Broadaway testified on his own behalf.

Closed Meeting: Dr. Gaskins moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia for the purpose of deliberation to reach a decision on the proposed consent order affecting the license of Derrick M. Broadaway, DDS. Additionally, he moved that Board staff, Ms. Reen, Ms. Vu, and Board counsel, Mr. Rutkowski attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Gaskins moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision: Dr. Gaskins moved to accept the Findings of Facts and Conclusion of Law as presented by the Commonwealth, amended by the Board, and read by Mr. Rutkowski. The motion was seconded and passed.

Dr. Gaskins moved to revoke Dr. Broadaway's license. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 1:51 a.m. on Saturday, May 10, 2014.

Melanie C. Swain, R.D.H., Vice-President	Sandra K. Reen, Executive Director
Date	Date

Agenda Item: AADB Reports by Dr. Levin and Ms. Palmatier

SUNDAY
APRIL 6, 2014

12:30 p.m. Registration, ADA Headquarters
Second Floor Foyer

1:00 p.m. Opening Remarks
Dr. Mark Christensen, UT, AADB President
Mr. James Tarrant, AADB Executive Director

GENERAL ASSEMBLY I - Scope of Practice and Standard of Care - Issues for Regulation

1:45 p.m. ADA Policies and Activities Related to Sedation and Anesthesia
- Dr. Teresa A. Dolan, MPH
Chair, ADA Council on Dental Education and Licensure; Vice President and Chief Clinical Officer, DENTSPLY International

2:15 p.m. Anesthesia Revised Guidelines
Dr. Michael Ellis, Chair, American Association of Oral and Maxillofacial Surgery Anesthesia Committee

2:45 p.m. COFFEE

3:00 p.m. Anesthesia Deaths in Dental Practice
- Dr. Joel Weaver, Dentist Anesthesiologist, Emeritus Professor, The Ohio State University

3:30 p.m. Policies, Guidelines and Regulations to Comply with New Standards - Botox and Dermafillers
- Dr. Peter Harnois, IL, American Academy of Facial Esthetics Senior Faculty

4:00 p.m. American Dental Association
- Dr. Charles H. Norman, III, President, American Dental Association

4:30 p.m. Health Insurance Exchange's Relevance to Dentistry
- Dr. Nicholas Panomitros, IL

5:00 p.m. Reception AADB Central Office, Ste. 760

MONDAY
APRIL 7, 2014

7:30 a.m. Registration, ADA Headquarters
Second Floor Foyer

7:45 a.m. COFFEE

8:00 a.m. Caucuses

8:30 a.m. Business Session

GENERAL ASSEMBLY II - Scope of Practice and Standard of Care - Issues for Regulation

9:15 a.m. Year in Review - Panel on Current Trends and Difficult Cases
- Mr. Mo Miskell, CO, Moderator
- Barbara Young, RDH, MA
- Bobbie White, Esq., NC
- Susan Rogers, Esq., OK

10:15 a.m. COFFEE BREAK

10:30 a.m. Anesthesia in Dental School Curriculum
- Dr. Robert Peskin, Director, Dental Anesthesiology Residency Program, Wyckoff Heights Medical Center

11:00 a.m. Specialty Licensure - Recognition and Restrictions - Analysis of States
- Dr. Dennis Manning, IL

11:30 a.m. National Dental Examiners' Advisory Forum (NDEAF)

Joint Commission Policy Update and Update on Progress on the Integrated Examination
- Dr. David Waldschmidt, ADA

12:00 p.m. LUNCH
Co-Sponsored by JCNDE
Crest & Oral B

BOARD ATTORNEYS' ROUNDTABLE

Sunday, April 6, 2014: 3:00 p.m. - 5:00 p.m.
Ritz Carlton Hotel Lobby

Monday, April 7, 2014: 9:00 a.m. - Noon
Conference Room A

- Angela Dougherty, Esq., WY, Co-Chair
- Lili Reitz, Esq., OH, Co-Chair

Thanks to Our Sponsors:

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Millennium Dental Technologies, Inc.

Save the Date!
131th AADB Annual Meeting
October 7 - 8, 2014
Hyatt Regency

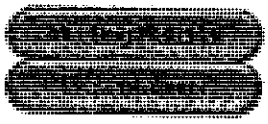
Search

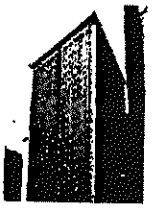
HOME MEETINGS POLICY REPORT PUBLICATIONS LINKS MEMBERS ONLY ABOUT AADB

AADB 131st AADB Annual Meeting
Oct. 7-8, 2014
Hyatt Regency
123 Losoya
San Antonio, TX

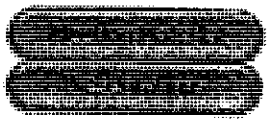
Past Meetings

- **AADB Mid-Year Meeting**
  April 6-April 7, 2014
  211 E. Chicago Avenue
  Chicago, IL 60611





- **AADB 130th Annual Meeting**
  Oct. 30-31, 2013
  Hyatt Regency
  New Orleans, LA



- **AADB Mid-Year Meeting**
  April 22-April 23, 2012
  211 E. Chicago Avenue
  Chicago, IL 60611

- **AADB Annual Meeting**
  October 17-18, 2012
  Hyatt Regency,
  San Francisco, CA

- **AADB Mid-Year Meeting**
  April 21-April 22, 2013
  211 E. Chicago Avenue
  Chicago, IL 60611

Presentations

AADB meetings provide an excellent forum for keeping up-to-date with state board concerns. Traditionally, the programs have been carefully designed to allow many opportunities for interaction among all participants including dentists, dental hygienists, educators, board attorneys and dental specialty associations. There are often panels as well as small discussion groups where ideas and information can be freely exchanged. Participants will be able to take away valuable information on how current issues affect all

Out of OR Procedural Sedations (Providers other than dentists)

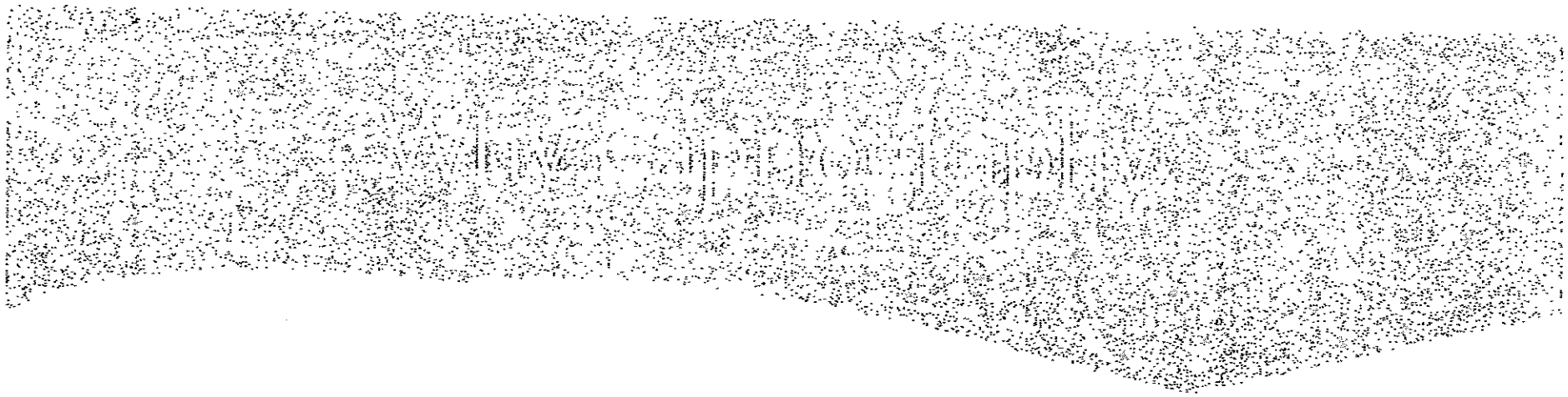
Respiratory depression is 17 times more likely to be detected when capnography is used in combination with pulse oximetry and visual inspection of the chest compared to a group without capnography

Capnography triggers early intervention

Incidences of severe hypoxemia (SpO2 less than 85%) decreased by greater than 50% with capnography

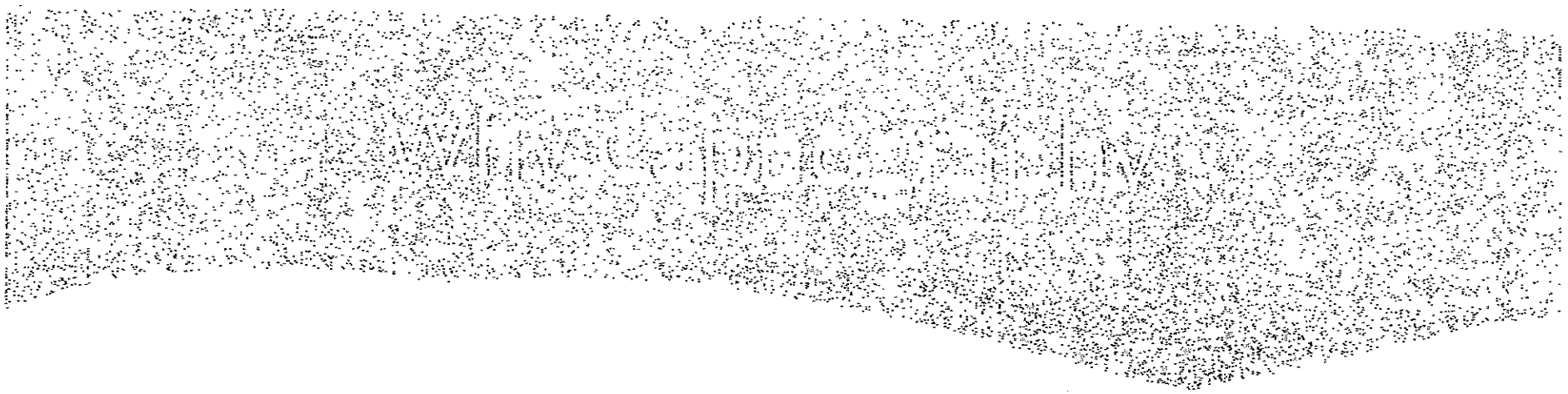
Capnography-ASA Standard

* Effective July 2011, recommend use of capnography for all procedures involving moderate and deep sedation.
* Moderate Sedation (Texas): drug induced depression of consciousness during which patient respond purposefully to verbal commands, either alone or accompanied by light tactile sensations. No interventions necessary to maintain a patent airway.
* Deep Sedation (Texas)-patient aroused only with repeated or painful stimulation, impaired ability to independently maintain ventilatory function…no requirement for $ETCO_2$ monitoring unless intubated

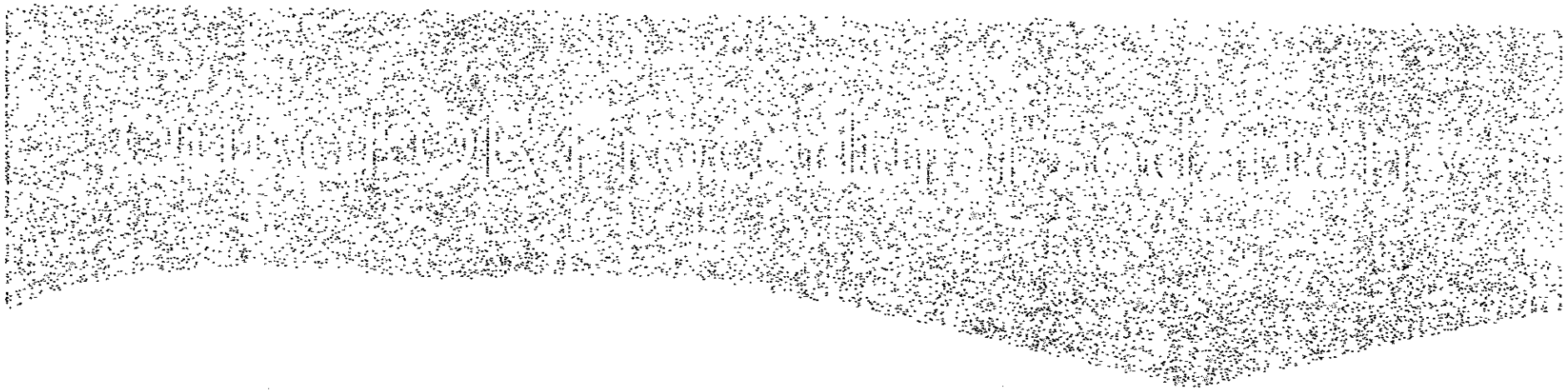


* Most common damaging event in Closed Claim database (22%) are respiratory events
* Hypoxic events more likely without capnography, which facilitates early detection
* Hypoxia occurs during routine procedures
* Routine use of capnography and increased experience heralds increased understanding of waveform interpretation

* In cases of airway obstruction, oxygenation levels can remain normal for some time, resulting in a detection delay that can cause apnea or hypoventilation to go unrecognized
* It is an effective method for clinicians to quickly recognize respiratory compromise



* Dilution of expiratory gases by supplemental oxygen or air may result in lower than normal ETCO2 values, so the importance is the detection of changes from baseline.
* Changes should trigger the provider to consider airway obstruction or respiratory depression. Simple maneuvers such as jaw thrust can overcome a partial airway obstruction as a result of excessive sedation.



* Versed and Ketamine
* Hypoxia observed in 25% of patients with capnography and 42% with blinded capnography
* Capnography forewarned respiratory depression in all cases of hypoxia
* Mean time from capnographic evidence of respiratory depression to hypoxia: 60 seconds

Crisis Management for Boards
Susan Rogers, Esq.

1. Prepare and plan for a crisis, eventually you will have one.
    a. Plan logistics and spokesperson.
    b. Make sure the spokesperson knows what they are talking about.
    c. Have basic background board information ready at all times.
    d. Plan your crisis team.
2. Understand what a reporter's job is.
    a. They are looking for a story to complete their assignment for the day.
    b. The media is different today than ten and twenty years ago.
    c. How stories are reported and new technology change every day.
    d. If you don't like the story they are going to write give them something else to write about.
3. In a crisis, be out front, take responsibility as best as you can and advise what you are going to do to correct it or do better for the future.
    a. If you run from the reporters they will believe you are hiding something and dig for information that will likely be misconstrued.
    b. This is a balancing act that you will need to discuss with other board members and/or your attorney depending on what the situation is.
4. There is no such thing as confidentiality with rare exceptions.
5. The media trend currently is sensationalism.
6. Know the methods in which you will communicate with your publics.
    a. Licensees
    b. Board members
    c. The general public
7. After the crisis passes, assess and prepare for the next time based on what you learned.

American Association of Dental Boards Mid-Year Meeting
Cosponsored by ADEA
April 6-7, 2014
ADA Headquarters Building, Chicago, Illinois

American Association of Dental Administrators update, Maulid (Mo) Miskell, CO

- Looking for ideas for Annual Meeting in Texas in October 2014
- Roundtable Discussion
  - Ohio
    - Dentist had legislation introduced to require the board to appoint an executive director and the term of office for the executive director shall be four years with reappointment to serve one additional term.
    - Have a new law dealing with summary suspension as a result of a lawsuit filed challenging the dental board's right to summarily suspend a licensee (An OMS was summarily suspended after his BAC was still .186 1 ½ hours after performing surgery)
    - Now performing random office inspection for infection control
  - Mississippi
    - New law that mandates that boards effect requirements for issuance of a license, certificate or registration to military-trained or military spouse applicants to lawfully practice their occupation in Mississippi under certain circumstances.
    - Attempting to change summary suspension law but dental association squashed attempt. Currently a license can only be summarily suspended under the Disabled Dentist Act.
    - Letters of Concerns are now being sent by Board Members for blatant violations of the law instead of their intended purpose of no violation but concern for an area of a licensee's practice.
  - Oregon
    - Ongoing issue - three new Board Members were calling each other and deciding how to vote on issues and complained to the Governor when the Executive Director informed them that was improper and constituted a meeting of the Board. Board members said the Executive Director was infringing on their First Amendment rights.
    - In 2004 the Oregon Board made a change to their Infection Control Guidelines when it changed from requiring monthly testing to weekly testing of heat sterilizing devices by means of a biological monitoring system that indicates micro-organisms kill. Following that Administrative Rule Change, every licensee was notified of that change and every Practice Act printed since that time and placed on their website has listed that new requirement. The Board started disciplinary actions against licensees and those who were disciplined went to the legislature. Legislature passed a bill that required the Board to dismiss disciplinary matters that were pending if the matter concerned whether a dentist tested an autoclave or other heat sterilization device less frequently than once a week and expunge from records findings and conclusions of disciplinary action taken. Required removal of name and repay licensee amount of penalty imposed pursuant to action. Issue has now become the Board cannot redact information from minutes or actual consent order.
  - DANB
    - Trying to address issues with sterilization techniques/requirements for certification
    - Verifying state dental practice acts links posted on website every quarter
  - Arkansas

- Hygienists may now provide prophylaxis, fluoride treatments, sealants, dental hygiene instruction, assessment of the patients' need for further treatment by a dentist, and other services provided by law if delegated by the consulting dentist to children, senior citizens, and persons with developmental disabilities in public settings without the supervision and direction of a dentist and without a prior examination of the patient by the consulting dentist
- Dental Assistants may now do sealants
- The Board's budget was being held until speak with legislature about issuance of specialty licenses just to obtain more money

- North Carolina
  - Disciplinary actions now being posted on the Board's website
  - There has been a second sedation death with a general dentist and the Board is revisiting regulations. Autopsy performed on first sedation death case but not on second so causing some issues about proving it was related to sedation
  - Supreme Court of the United States granted Petition for Writ of Certiorari in case against Federal Trade Commission. Oral argument hopefully in fall 2014.
- Massachusetts
  - DentaQuest, Governor, et al. are being sued by patients and Medicaid Orthodontists of Massachusetts Association, Inc. (MOMA) to resolve question of whether DentaQuest violates the Massachusetts Consumer Protection Act, G.L. c. 93A, § 9 by assigning incompetent and unlicensed individuals to diagnose. The argument is that the dentists that DentaQuest are hiring as utilization reviewers approve or deny treatment for each case submitted, which involves the interpretation of X-rays and photographs and other medically relevant information and requires the reviewer to make a diagnosis. Massachusetts dental practice act are so broad that "if you pick up an explorer and look in the mouth you are practicing dentistry" and the plaintiffs argue DentaQuest is allowing unlicensed individuals from Wisconsin to make diagnosis. MOMA filed complaints with the Board as well for unlicensed activity.
  - Board continues to work on regulations for dental assistants
  - Working on advanced practice regulations for dental hygienists – simple extractions, simple crowns and bridges, simple fillings
- Tennessee
  - Dental association wants to be able to do dermal fillers and Botox. The Board believes the Attorney General's office will say there must be a statutory change to allow general dentists to do.[1]
- Idaho
  - Proposed statute requiring self-reporting of criminal convictions died in the Senate
  - Any licensed dentist can perform treatment under minimal sedation but recently added requirement that only one agent could be used for patients sixteen (16) and under
- Maryland
  - Expect the "standard of care" legislation to pass[2]
  - Working on a "Code of Conduct" document
- Arizona

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[11] At the time this report was drafted, the Attorney General issued an opinion on April 24, 2014 that "the Tennessee Board of Dentistry therefore may, within its discretion, promulgate a rule allowing such procedures [Botox, other FDA-approved neurotoxins, or dermal fillers] to be performed by general dentists; in doing so the board is vested by Tenn. Code Ann. §§ 63-5-105(7) and 63-5-108 with authority to impose educational, training, and experience requirements upon those licensees who would engage in such practice."

[2] At the time this report was drafted, the Maryland legislature passed and the Governor signed into law a statute that authorizes the State Board of Dental Examiners to take disciplinary actions against applicants for a license to practice dentistry or dental hygiene, licensed dentists, or licensed dental hygienists if the applicant or licensee demonstrates a course of conduct or provides a service that is inconsistent with the standard of care for their profession.

        - Currently being audited by Auditor General
        - 25%+ of complaints concern implants by general dentists
    - Colorado
        - Working on Sunset Review of laws – the bill had amendments to continuing education requirements, and requirement to register with PMP at time of renewal
        - No issues yet with practitioner impairment as a result of legalizing marijuana
    - Minnesota
        - Sent out a survey to licensees in December with questions about requiring criminal background checks for licensure, inspections for infection control and whether the CPR requirement should be for healthcare providers
    - Missouri
        - Legislation was introduced that no new regulations could be enacted unless it could be shown there is a public health issue. This means no changes in licensure fees

AADB President Update, Dr. Mark Christensen, UT

- AADB Assessment Services Program (ASP) coming on line soon. Comprehensive program of review services designed to assist dental boards throughout the discipline process and includes two major components: Dentist-Professional Review and Evaluation Program (D-PREP) and the Expert Review Assessment (ERA).
    - D-PREP evaluates and suggests possible remediation of deficiencies in dental practitioners referred to the program by their boards. Designed to identify practitioners who need remediation or who should not continue in the practice of dentistry. Dental practitioners referred to this program by their boards will be assessed and, if qualified, have the opportunity to participate in an enhancement program that will address their deficiencies and enable them to return to dental practice. AADB working with University of Maryland, Marquette University and Louisiana State University who will act as the assessment centers for practitioners referred to the program. Approximately 6 practitioners already referred this year.
    - The Expert Review Assessment program provides independent expert witness in disciplinary case review. Experts in specialty fields will review the practitioner's patient care and treatment and/or the practitioner's conduct and offer an opinion regarding whether or not that care, treatment and conduct met applicable standards.
- Links for each state's dental practice act online in coordinated effort with DANB.

ADA Policies and Activities Related to Sedation and Anesthesia, Teresa A. Dolan, DDS; Chair, ADA Council on Dental Education and Licensure; VP and Chief Clinical Officer, DENTSPLY International

- Council on Dental Education and Licensure
    - Monitor and disseminate information on dental education and licensure issues
    - Provide recommendations to the ADA's policy-making bodies on dental education and licensure issues
    - Serve as liaison to related dental education and licensure organizations
    - Implement the directions of the Board of Trustees and the House of Delegates of the ADA
    - Working on a review of ADA anesthesia policies to require the use of capnography during moderate sedation in an open airway system (non-intubated patient)
        - Current ADA Use Guidelines require use of a capnograph when volatile anesthetic agents are used
    - Working on a revision to the ADA's CE course: Managing Sedation Complications

- Developed in 2008-09
- Goal is to teach dentists to manage, prior to arrival of EMS, airway and medical emergencies that can occur during administration of minimal and moderate sedation
- Part 1 offered via ADA CE Online (didactic = 4 CEUs)
- Part 2 offered by ADA or a sub licensee (hands on ½ day course = 5 CEUs)

A Consideration of AAOMS Initiatives in Anesthesia, Michael Ellis, DDS, AAOMS Committee on Anesthesia

- Problems with Anesthesia
  - Is a pre-op physical exam being completed?
  - Do the provider and assistant have appropriate training in administering anesthesia?
  - Is there anesthetic team communication and readiness in an emergency?
  - Is the appropriate monitoring being done?
  - Are there equipment/system failures?
  - Is there organization of the emergency equipment, medications and supplies?
  - Do you have appropriate medications to deal with an emergency?
  - Inattentiveness?
  - Is EMS notified early enough of emergency situation?
  - Crisis Management Algorithm in place?

- Judging the typicality of the situation
  - I have seen this before, it is an anomaly, and I better do something about it
  - I have practiced this before, it is an anomaly, and I will address the problem in a controlled, timely and sequential manner
  - I have no experience with this problem
  - Must rely on tacit knowledge and experience: with no experience, you better have some knowledge
  - Captain Sullenberger analogy

- American Society of Anesthesiologists (ASA) Closed Claims Out of Hospital Events
  - Data suggests that anesthesia in remote locations poses a significant risk for the patient with regard to oxygenation and ventilation
  - Respiratory damaging events more common
  - Death is increased
  - Inadequate oxygenation/ventilation was the most common specific event
    - Currently the standard of care for non-intubated patients is the use of a pulse oximeter
    - Respiratory depression is seventeen times more likely to detected when capnography is used in combination with pulse oximeter and visual inspection of the chest
    - Capnography triggers early intervention and incidences of sever hypoxemia is decreased by greater than 50% with its use
    - ASA has incorporated the use of capnography into their standards for all procedures involving moderate and deep sedation

- AAOMS
  - January 2014 incorporated use of ETCO2 monitoring
  - Based on idea that sedation is a continuum and that it is impossible to predict how an individual patient will respond to an administered sedative
  - Current CMS guidelines require anesthesia departments to oversee procedural sedation in institutions, thus prudent to follow ASA standards to monitor ventilation with capnography
  - Hypoxic events more likely without capnography which facilitates early detection
  - Hypoxia occurs during routine procedures
  - Dilution of expiratory gases by supplemental oxygen or air may result in lower than normal ETCO2 values, so the importance is the detection of changes from the baseline

- Changes should trigger the provider to consider airway obstruction or respiratory depression. Simple maneuvers such as jaw thrust can overcome a partial airway obstruction as a result of excessive sedation
- In cases of airway obstruction, oxygenation levels can remain normal for some time, resulting in a detection delay that can cause apnea or hypoventilation to go unrecognized

- AQI-NACOR
  - AQI- Anesthesia Quality Institute
  - NACOR - National Anesthesia Clinical Outcomes Registry
  - AAOMS has committed in principle to collaborate with AQI for the development of an anesthesia registry and develop a database of adverse anesthesia-related events
    - Anesthesia Adverse Events - information about time, place, environment, equipment, events/narratives, people present, synopsis, AAR/Assessment
    - Practitioner Issues - relies on self-reporting, guilt and malpractice, standing in community, economic damages

- High-Fidelity Simulation
  - Airway management
  - Patient resuscitation
  - Medication management
  - Team communication

- Bottom Line
  - OAE – equipment, medications, crisis management
  - Capnography – indispensible asset for early warning of hypoxia
  - Interim training of provider and staff – DAANCE, simulation, MOCA, consideration of anesthesia-specific requirements by state boards, completing continuing education courses does not imply competence

Anesthesia Deaths in Dental Practice, Joel M. Weaver, DDS, PhD, Dentist Anesthesiologist, Emeritus Professor, Ohio State University

- Are Dental Office Deaths Rare?
  - Unfortunately no
  - Number of cases are probably increasing
  - No clearinghouse to tabulate deaths
  - Minimal sharing of information

- Why Do Most Death Cases Happen?
  - "Pilot Error"
  - Poor judgment as to when not to administer anesthesia
  - Unable to recognize impending crisis
  - Unable to correct error quickly
  - No regular emergency simulation training

- Sedation and Anesthesia Mishaps
  - Course emphasis on how to sedate
  - Minimal emphasis on who not to sedate
  - Courses taught by non-experts instead of anesthesia specialists and educators
  - Few anesthesia experts teach in dentistry

- Erroneous Teaching
  - Two bowling ball-sized triazolam tablets to harm. WRONG
  - Sublingual injection of 0.2mg flumazenil reverses triazolam overdose. WRONG
  - Reverse all sedations to speed recovery so patient can go home sooner. WRONG

        - Completely reversing doesn't work because reversing agents wear off and sedative begin "working" again and usually the patient is not being monitored

- Patient Risk Factors
    - Medical Conditions
        - Morbid obesity
        - Obstructive sleep apnea
        - Respiratory disease
        - Cardiovascular disease
        - Debilitated patient (low protein binding, renal failure, CHF)
    - Patient age extremes
        - Very young and very old
    - Dental procedure
        - Procedure/dentist demands minimal patient movement

- Common Causes of Dental Office Deaths
    - Airway
    - Excessively deep sedation
    - Unconsciousness
    - Pharyngeal soft tissues relax
    - Upper airway obstruction
    - Loss of airway patency – apnea
    - Hypoxic brain damage
    - Cardiac arrest
    - Paramedics resuscitate O2 and heart
    - Coma – brain death - death

- Obstructive Sleep Apnea
    - No problem when patient awake
    - Soft tissue obstruction when sleeping
    - Stop ventilation – oxygen level drops
    - Brain awakens patient just before death
    - Patient breathes, O2 rises, CO2 falls
    - Patient falls asleep again
    - Cycle repeats

- Intraoperative Sedation Deaths in OSA patients
    - Sedated brain less sensitive to hypoxia
    - Brain may not be able to awaken patient
    - Obstructed patient does not breathe
    - Hypoxia leads to brain damage
    - Cardiac arrest inevitable without oxygen
    - Heart can be restarted by brain is dead

- Postoperative Sedation Deaths in OSA patients
    - Patient recovers from sedation
    - Goes home to rest
    - Patient takes 2 Percocet tablets for pain
    - Falls asleep with residual sedative drugs
    - Percocet adds to the residual sedative
    - Decreases brain sensitivity to hypoxia
    - Severe OSA is potentiated
    - Patient found dead at home

- Other Predisposing Problems Loss of Airway
    - Large tonsils
    - Trismus

- TMJ disturbances
- Small mouth opening and retrognathia
- High arched narrow width palate
- Large tongue
- Rheumatoid arthritis
- Cancer surgery/radiation treatment neck/mouth
- Cervical spine fusion
- Full beard

- How to Enhance Safety?
  - Pass strict, fair rules
  - Rules based on ADA Guidelines
  - Strict training for sedation/anesthesia permits
  - Rules to encourage dentists with extensive training to practice in your state
  - Thorough, fair inspection of permit holders
  - Inspectors should be non-competitors
  - One inspector must have similar practice
  - Inspectors prepared by experts

Policies, Guidelines and Regulations to Comply with New Standards-Botox and Dermal Fillers, Dr. Peter Harnois, AAFE

- ADA definition of dentistry - the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body
  - Has been considered dentistry when treatment down back for TMJ pain
- Botox and dermal fillers are pharmaceutical agents (like anti-biotics)
- When Botox and dermal fillers are used within the scope of the definition of dentistry, then their use is dentistry
- Dentistry not limited to intraoral and perioral
- When Boards decide Botox and dermal fillers cannot be used for aesthetic purposes, it is against the dental practice act. Making underground regulation that hasn't gone through the regulatory process

ADA, **Dr. Charles H. Norman, III, President**

- Working on common content exam and a patient selection process
- Dental environment becoming such that the scope of practice is encompassing prevention and taking a greater role. Dentists may be doing initial screenings for diabetes, vaccinations, etc. and Boards are going to need to address this environment. Consumers are expecting more for less and are never establishing medical providers.

Health Information Exchange, Nicholas Panomitros, DDS, MA, JD, LLM, CPHI

- Part I - The Future of Health Care – The Role of Data
  - HIE Fundamentals
    - Improved patient health outcomes
    - Better care and coordination among providers
    - Reduced medical errors
    - Improved public health monitoring and response
    - Controlled health care costs
  - Government Promotion of HER & HIE
    - Allocation of funding to advancement of health information technology
  - Legal Issues: Privacy and Security

        - Controlling disclosure by custodian – by usage purpose, patient consent
        - HIPPA and state laws
- Part II – Evolving Privacy and Security Policies
    - Multi-staged approach to implementation of HIE and the privacy and security policies which current technology enables
    - Harmonization of state and federal laws
    - Encourage flow of PHI into HIE for HIE purposes, but provide patient privacy protection with patients being given "opt-out" choice for HIE participation
    - Adopt measures to build provider and patient trust in the HIE

Specialty Licensure – Recognition and Restriction, Dr. Dennis Manning, IL State Board of Dentistry

- Nine ADA recognized specialties
- Seventeen states have a specialty license procedure or requirements
    - All reference the educational standards set forth by an/some ADA agency (e.g., CODA, Council on Dental Education, Council on Dental Education and Licensure, Council on Dental Accreditation, etc.)
    - Thirteen require graduation from a CODA-accredited program; Four reference outdated ADA information
- Thirty-three states are silent
- Dental board determines which specialties will be licensed in a given state
- In 2012, Alaska became the first and only state known to the ADA to repeal specialty licensure
- NERB administers examinations in seven specialty areas: Endodontics, Orthodontics and Dentofacial Orthopedics, OMS, OMR, Pediatric Dentistry, Periodontics, Prosthodontics
    - Designed to qualify successful applicants to practice and advertise themselves as specialists in states participating in this specialty exam process
        - Not intended to replace the specialty certifying boards
    - 40-60 candidates undergo this exam each year
    - Annual pass rate 95-100%
    - Two parts – written multiple choice of 160-180 questions, presentation of a series of cases completed by the candidate demonstrating specific treatment planning and technical skills
    - Passing score of 75% required on both parts

Respectfully submitted by,

Kelley W. Palmatier
Deputy Executive Director

ADEX

American Board of Dental Examiners, Inc.

a test development agency for the member state dental boards

2012-2013 Annual Report

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Message from the President

Welcome to the Ninth Annual ADEX House of Representatives Meeting. We are excited that today marks the eighth full year of the initial licensure examinations in dentistry and dental hygiene. Our growth has continued to be outstanding with the addition of the Council of Interstate Testing Agencies (CITA) and its member state boards of Alabama, North Carolina and Puerto Rico. By taking the ADEX examination, a candidate is now eligible for licensure in 90% of the country.

ADEX has become the largest test development entity for dentistry in the United States. It is currently being given to students at 38 dental schools as well as being recognized in 45 jurisdictions: 43 states plus the District of Columbia and Puerto Rico. We also are anticipating more states coming aboard throughout the coming year.

This rate of growth we are experiencing can be directly related to the enthusiasm and dedication of our ADEX members. We are continually striving to deliver superior examinations that are both valid and reliable.

On behalf of ADEX, thank you for taking time out from your busy schedules to participate in the ADEX process and ultimately making our dream of a single, uniform, national examination a reality.

Bruce Barrette, DDS
President, ADEX

ADEX Membership

Membership gives a recognizing state dental board direct involvement in the development and evolution of the examinations through committee appointments; and approval of the final form of the examinations in dentistry and dental hygiene through their appointments to the House of Representatives.

Consumer members of state dental boards are full active voting members of ADEX directly involved in the evolution and participation of the examinations.

Member Jurisdictions

Alabama
Arkansas
Colorado
Connecticut
District of Columbia
Florida
Hawaii
Illinois
Indiana
Iowa
Kentucky
Maine
Maryland
Massachusetts
Michigan
Mississippi
North Carolina
New Mexico
Nevada
New Hampshire
New Jersey
Ohio
Oregon
Pennsylvania
Puerto Rico
Rhode Island
South Carolina
Tennessee
Wyoming
Vermont
Virginia
West Virginia
Wisconsin

ADEX

ADEX Districts

ADEX initial districts were drawn to try to equalize the number of dental students, dentists licensed each year, and to some degree practicing dentist numbers.

District 1:	California
District 2:	Alaska, Arizona, ***Colorado, Hawaii***, Idaho, Montana, ***Nevada, New Mexico, Oregon***, Utah, Washington, ***Wyoming***
District 3:	Kansas, Missouri, Nebraska, Oklahoma, Texas
District 4:	***Iowa***, Minnesota, North Dakota, South Dakota, ***Wisconsin***
District 5:	***Illinois, Indiana, Michigan, Ohio***
District 6:	***Arkansas***, Georgia, ***Kentucky, South Carolina, Tennessee, Virginia, West Virginia***
District 7:	***Maryland, Pennsylvania***
District 8:	***Connecticut***, Delaware, ***District of Columbia***, U.S. Virgin Islands
District 9:	***New Hampshire, New Jersey***, New York, ***Rhode Island***
District 10:	***Maine, Massachusetts, Vermont***
District 11:	***Alabama***, Louisiana, ***Mississippi, North Carolina, Puerto Rico***
District 12:	***Florida***

States highlighted in ***bold italics*** are Member States

ADEX Governance

Governing Principle

ADEX's governing principle is that the governing authority is vested with the active member state boards of dentistry. Representatives are directly appointed by the active state dental board and the directors elected by state board representatives.

Important committee appointments are directly made through the representatives of the active state dental boards.

House of Representatives

Governance is from the Member State Dental Boards in the House of Representatives.

- The House of Representatives consists of dentist or executive director representatives from the member state dental boards. They hold final approval of major examination changes.
- Each state board will designate one representative.
- Representatives are required to have been active voting board members of the member state at some time.
- A Dental Hygiene representative from each ADEX district is required to be or have been an active board member from a member state.
- A Consumer representative from each ADEX district is required to be or have been an active board member from a member state.
- Each state will determine the qualifications of their representative.
- Members from American Dental Association (ADA), American Student Dental Association (ASDA), American Dental Education Association (ADEA), American Dental Hygienists' Association (ADHA), The National Dental Examining Board of Canada (NDEB), Canadian Dental Association (CDA), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) are chosen by their respective organizations.

2012 ADEX House of Representatives

Dentist or Executive Director Representatives

Arkansas – H. Warren Whitis, DDS

Colorado – Mr. Maulid Miskell

Connecticut – David Perkins, DDS

District of Columbia – Robert Ray, DMD

Florida – William Kochenour, DDS

Hawaii – Mark Baird, DDS

Illinois – Dennis Manning, DDS

Indiana – Stephen Pritchard, DDS

Iowa – No Representative

Kentucky – Katherine King, DDS

Maine – No Representative

Maryland – Ngoc Chu, DDS

Massachusetts – Mina Paul, DDS

Michigan – William Wright, DDS

Mississippi – Carl Boykin, DDS

Nevada – Jade Miller, DDS

New Hampshire – Arthur McKibbin, DMD

New Jersey – Peter DeSciscio, DDS

New Mexico – Robert Gheradi, DDS

Ohio – Jacinto Beard, DDS

Oregon – Patricia Parker, DMD

Pennsylvania – John V. Reitz, DDS

Rhode Island – M. Christine Benoit, DMD

South Carolina – Z. Vance Morgan, DMD

Tennessee - Michael Tabor, DDS

Virginia – Martha Cutright, DDS

Vermont – David Averill, DDS

West Virginia – Craig Meadows, DDS

Wisconsin – Keith Clemence, DDS

Wyoming – Scott Houfek, DDS

2012 ADEX House of Representatives (cont.)

Dental Hygiene Representatives

Mary Davidson, RDH, MPH, OR	District 2
Nan Dreves, RDH, MBA, WI	District 4
Mary Johnston, RDH, MI	District 5
Mary Ann Burch, KY	District 6
Cheryl Bruce, RDH, MD	District 7
Sibyl Gant, RDH, DC	District 8
Nancy St. Pierre, RDH, NH	District 9
Karen Dunn, RDH, MA	District 10
No Representative	District 11
Irene Stavros, RDH, FL	District 12

Consumer Representatives

No Representative	District 2
Ms. Judith Ficks, WI	District 4
Ms. Clance LaTurner, IN	District 5
No Representative	District 6
Allan Horwitz, Esq., PA	District 7
No Representative	District 8
Ms. Lynn Joslyn, NH	District 9
Ms. Diane Denk, ME	District 10
Ms. Vicki Campbell, FL	District 12

2012 ADEX House of Representatives (cont.)

Associate Members

American Dental Association – Maxine Feinberg, DDS, ADA Trustee

American Student Dental Association – Mr. Ben Youel, President

American Dental Education Association – Peter Robinson, DDS

American Dental Hygienists' Association – No Representative

National Dental Examining Board of Canada – No Representative

Canadian Dental Association – No Representative

Federation of State Medical Boards – David Johnson

National Board of Medical Examiners – No Representative

ADEX Board of Directors

ADEX Officers

Bruce Barrette, DDS	Wisconsin	President
Stanwood Kanna, DDS	Hawaii	Vice-President
William Pappas, DDS	Nevada	Secretary
Robert Jolly, DDS	Arkansas	Treasurer
Guy Shampaine, DDS	Maryland	Immediate Past President

ADEX Board of Directors – Up to 17 Members

12 Districts, Examination Committee Chairs, Dental Hygiene Representatives

Directors elected by state board representatives in House of Representatives

Board of Directors

Patricia Parker, DMD	Oregon	District 2
Keith Clemence, DDS	Wisconsin	District 4
M.H VanderVeen, DDS	Michigan	District 5
Michelle Bedell, DMD	South Carolina	District 6
John Reitz, DDS	Pennsylvania	District 7
Robert Ray, DMD	DC	District 8
Peter DeSciscio, DMD	New Jersey	District 9
Richard Dickinson, DDS	Maine	District 10
Jeffrey Hartsog, DDS	Mississippi	District 11
Wade Winker, DDS	Florida	District 12
Ms. Judith Ficks	Wisconsin	Consumer Member
Clance LaTurner	Indiana	Consumer Member
Mary Johnston, RDH	Michigan	Hygiene Member
James "Tuko" McKernan, RDH	Nevada	Hygiene Member
Nan Kosydar Dreves, RDH, MBA	Wisconsin	Chair, Dental Hygiene Examination Committee
Scott Houfek, DDS	Wyoming	Chair, Dental Examination Committee

Terms for Current ADEX Board of Directors*

District	Incumbent	Remaining Tenure
District 2	Patricia Parker, DMD*	2 Years
District 4	Keith Clemence, DDS*	2 Years
District 5	M. H. VanderVeen, DDS*	0 Years
District 6	Michelle Bedell, DMD*	1 Years
District 7	John Reitz, DDS*	2 Years
District 8	Robert Ray, DMD	0 Years
District 9	Peter DeSciscio, DMD	0 Years
District 10	Richard Dickinson, DDS	1 Years
District 11	Jeffrey Hartsog, DDS*	2 Years
District 12	Wade Winker, DDS*	1 Years
Consumer Member	Ms. Judith Ficks	0 Years
Consumer Member	Ms. Clance LaTurner*	2 Years
Hygiene Member	Mary Johnston, RDH	2 Years
Hygiene Member	James "Tuko" McKernan, RDH*	0 Years

* members of the Board of Directors are eligible to serve a second three-year term if elected by their district.

ADEX Committees

Dental Examination Committee

- One (1) dentist from each Member Board.
- One (1) Member Board consumer representative
- 1 Consumer
- The Chair of the Dental Examination Committee
- All appointments are nominated by the representatives of the member state dental boards.

Dental Examination Committee Members

Scott Houfek, DDS, WY – Chair

District 2: (CO, HI, NV, NM, OR, WY)
Lisa Fox, DDS, CO
Stan Kanna, DDS, HI
William Pappas, DDS, NV
TBD, NM
Jonna Hongo, DMD, OR
TBD, WY
Rick Thiriot, DDS, NV Educator

District 4: (IA, WI)
TBD, IA
Keith Clemence, DDS, WI
Leo Huck, DDS, WI Educator

District 5: (IL, IN, MI, OH)
Dennis Manning, DDS, IL
Matthew Miller, DDS, IN
Chuck Marinelli, DDS, MI
Eleanore Awadalla, DDS, OH
Peter Yaman, DDS, MI, Educator

Dental Examination Committee Members (cont.)

District 6: (AR, KY, SC, TN, VA, WV)
- George Martin, DDS, AR
- Robert Zena, DDS, KY
- Z. Vance Morgan, IV, DMD, SC
- John M. Douglas, Jr. DDS, TN
- James Watkins, DDS, VA
- John Dixon, DDS, WV
- Rick Archer, DDS, VA Educator Rep

District 7: (MD, PA)
- Guy Shampaine, DDS, MD
- Susan Calderbank, DMD, PA
- Uri Hangorski, PA, Educator

District 8: (CT, DC)
- David Perkins, DMD, CT
- Renee McCoy-Collins, DDS, DC
- John Bailey, DDS, DC, Educator

District 9: (NH, NJ, RI)
- Barbara Rich, DMD, NJ
- Arthur McKibbin, Jr., DMD, NH
- Henry Levin, DMD, RI
- Marc Rosenblum, DMD, NJ, Educator

District 10: (MA, ME, VT)
- Robert DeFrancesco, DMD, MA
- LeeAnn Podruch, DDS, VT
- Rockwell Davis, DDS, ME
- Stephen DuLong, DMD, MA, Educator

District 11: (AL, LA, MS, NC, PR)
- Thomas T. Willis, Jr., DDS, AL
- A. Roddy Scarbrough, DMD, MS
- Milliard "Buddy" Wester III, DDS, NC
- Augusto Cesar Garcia-Aguirre, DDS, PR
- Larry C. Breeding, DMD, MS, Educator

District 12: (FL)
William Kuchenour, DDS, FL
Amir Farhangpour, DDS, FL, Educator

Dental Examination Committee Members (cont.)

Consumer:
Alan Horwitz, Esq., PA

Testing Specialist:
Steven Klein, Ph.D, CA

Ex-Officio:
Bruce Barrette, DDS, WI ADEX President

NERB Administrative Liaison:
Ellis Hall, DDS, MD

SRTA Administrative Liaison:
Kathleen White, VA

CITA Administrative Liaison
Sam Trinca, LA

ADEX Committees (cont.)

Dental Hygiene Examination Committee

- 1 Dental Hygienist from each district
- 1 Dental Hygiene Educator
- 1 Dentist
- 1 Consumer
- All appointments are nominated by the active member state dental boards.

Dental Hygiene Examination Committee Members

Nanette Kosydar Dreves, RDH, MBA, WI – Chair

District 2: Jill Mason, RDH, MPH, OR

District 4: Beth Clemence, RDH, WI

District 5: Lynda Sabat, RDH, OH

District 6: Diana Vaughan, RDH WV

District 7: Marellen Brickley-Raab, RDH, PA

District 8: Judith Neely, RDH, BS, DC

District 9: Shirley Birenz, RDH, BS, NJ

District 10: Karen Dunn, RDH, MA

District 11: Janet Brice McMurphy, RDH, MS

District 12: Irene Stavros, RDH, FL

Dentist: Maxine Feinberg, DDS, NJ

Educator: Donna Homenko, RDH, PhD, OH

Consumer: Zeno St. Cyr II, MPH, MD

NERB Administrative Liaison: Michael Zeder, MD

SRTA Administrative Liaison: Sherie Williams Barbare, RDH, SC

Testing Specialist: Steven Klein, Ph.D, CA

ADEX President - Ex-Officio, Bruce Barrette, DDS, WI

ADEX Committees (cont.)

Budget Committee

Robert Jolly, DDS, AR - Chair
Scott Houfek, DDS, WY
Neil Hiltunen, DDS, NH
Tony Guillen, DDS, NV
Guy Shampaine, DDS, MD
Charles Ross, DDS, FL
Kathleen White, VA
Bruce Barrette, DDS, WI - ADEX President Ex-Officio

Bylaws Committee

Robert Ray, DDS, WI - Chair
Garo Chalian, DDS, CO
James "Tuko" McKernan, NV
Alan Horowitz, Esq., PA
Bruce Barrette, DDS, WI - ADEX President Ex-Officio

Calibration Committee

William Pappas, DDS, NV - Chair
Scott Houfek, DDS, WY
Tony Guillen, DDS, NV
Rick Thiriot, DDS, NV
Neil Hiltunen, DDS, NH
Ogden Munroe, DDS, IL
Ken Van Meter, DDS, VT
Rick Kewlowitz, DDS, FL
Wendell Garrett, DDS, AR
Richard Marshall, DDS, WV
Peter Yaman, DDS, MD
Bruce Barrette, DDS, WI - ADEX President Ex-Officio

Communications Committee

Clance LaTurner, IN - Chair
Stanwood Kanna, DDS, HI
Kathy Heier, RDH, IL
Mary Davidson, RDH, OR
Mary Johnston, RDH, MI
Bruce Barrette, DDS, WI - ADEX President Ex-Officio

ADEX Dental Examination

Content

- Five stand alone examinations
  - Critical skill sets identified by criticality in the Occupational Analysis
- Computerized Examination in Applied Diagnosis and Treatment Planning
- Endodontic Clinical Examination
  - Manikin-based
- Fixed Prosthodontic Clinical Examination
  - Manikin-based
- Restorative Clinical Examination
  - Patient-based
- Periodontal Clinical Examination
  - Patient-based

Scoring

- Criterion based scoring system
- Three (3) independent raters without collaboration

Rating Levels

- Satisfactory
- Minimally Acceptable
- Marginally Substandard
- Critically Deficient

ADEX Dental Exam Scoring

Criterion-Based Analytical Scoring Rubric:

- More detailed feedback.
- More consistent scoring.
- Allows for the separate evaluation of factors.
- Evaluation of all gradable criteria.
- Scoring methodologies were developed with consultation from the Buros Institute, University of Nebraska and the Rand Institute with input from studies completed by testing specialists from the University of Chicago.
- Three (3) independent raters evaluate all measurable criteria.
- Median score is utilized when there are no matching scores; all zeros must be independently corroborated to be utilized as a critical deficiency.
- Performance criteria-based scoring will be provided to both the candidate and the dental school so that appropriate remediation can be completed prior to a retake when required.
- Clinical sections utilize compensatory grading with critical errors within a skill set.
- No grading across skills.
- Critical errors are those performance deficiencies that would cause treatment to fail. A critical error forces a failure on that skill set examination. Not all criteria have critical errors.

Evaluation Criteria

Objective measurable criteria developed by a panel of experts consisting of examiners, practitioners, and educators.

Amalgam Prep External Outline Criteria (Example)

SATISFACTORY

1. Contact is visibly open proximally and gingivally up to 0.5 mm.
2. The proximal gingival point angles may be rounded or sharp.
3. The isthmus must be 1-2 mm wide, but not more than ¼ the intercuspal width of the tooth.
4. The external cavosurface margin meets the enamel at 90°. There are no gingival bevels. The gingival floor is flat, smooth and perpendicular to the long axis of the tooth.
5. The outline form includes all carious and non-coalesced fissures, and is smooth, rounded and flowing.
6. The cavosurface margin terminates in sound natural tooth surface. There is no previous restorative material, including sealants, at the cavosurface margin. There is no degree of decalcification on the gingival margin.

MINIMALLY ACCEPTABLE

1. Contact is visibly open proximally, and proximal clearance at the height of the contour extends beyond 0.5 mm but not more than 1.5 mm on either one or both proximal walls.
2. The gingival clearance is greater than 0.5 mm but not greater than 2 mm.
3. The isthmus is more than ¼ and not more than 1/3 the intercuspal width.
4. The proximal cavosurface margin deviates from 90°, but is unlikely to jeopardize the longevity of the tooth or restoration; this would include small areas of unsupported enamel.

MARGINALLY SUBSTANDARD

1. The gingival floor and/or proximal contact is not visually open; or proximal clearance at the height of contour extends beyond 1.5 mm but not more than 2.5 mm on either one or both proximal walls.
2. The gingival clearance is greater than 2 mm but not more than 3 mm.
3. The outline form is inappropriately overextended so that it compromises the remaining marginal ridge and/or cusp(s).
4. The isthmus is less than 1 mm or greater than 1/3 the intercuspal width.
5. The proximal cavosurface margin deviates from 90° and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s).
6. The cavosurface margin does not terminate in sound natural tooth structure; or, there is explorer penetrable decalcification remaining on the cavosurface margin, or the cavosurface margin terminates in previous restorative material. *(See glossary under Previous Restorative Material).*
7. There is explorer-penetrable decalcification remaining on the gingival floor.
8. Non-coalesced fissure(s) remain which extend to the DEJ and are contiguous with the outline form.

CRITICAL DEFICIENCY

1. The proximal clearance at the height of contour extends beyond 3 mm on either one or both proximal walls.
2. The gingival clearance is greater than 3 mm.
3. The isthmus is greater than ½ the intercuspal width.
4. The outline form is overextended so that it compromises, undermines and leaves unsupported the remaining marginal ridge to the extent that the pulpal-occlusal wall is unsupported by dentin or the width of the marginal ridge is 1 mm or less.

Endodontic Clinical Examination on a Simulated Patient (Manikin)

Part II: Endodontics – 18 Scorable Items

- Anterior Endodontic Procedures — 12 Criteria
  - Access Opening
  - Canal Instrumentation
  - Root Canal Obturation
- Posterior Access Opening — 6 Criteria

Fixed Prosthodontic Examination on a Simulated Patient (Manikin)

Part III: Fixed Prosthodontics – 43 Scorable Items

- Cast Gold Crown — 15 Criteria
- Porcelain-Fused-to-Metal Crown — 14 Criteria
- Ceramic Crown Preparation — 14 Criteria
- Preparations 1 & 2 evaluated as a mandibular posterior 3-unit bridge

Part V: Restorative – 47 Scorable Items

- Class II Amalgam Preparation — 16 Criteria
- Amalgam Finished Restoration — 9 Criteria
- Class III Composite Preparation — 12 Criteria
- Composite Finished Restoration — 10 Criteria

Periodontal Clinical Examination

Treatment Selection (Procedural)

- Patient Selection severity of periodontal disease.

Treatment

1. Subgingival Calculus Detection
2. Subgingival Calculus Removal
3. Plaque/Stain Removal
4. Pocket Depth Measurement
5. Treatment Management

ADEX Dental Post-Exam Analysis

- Technical Report Developed
- Demographic Data/Analysis
  - Conducted by respective administering agencies
  - Synopsis of data provided for Restorative and Periodontal Procedures with several years of history:

Demographic Data on the Candidate Pool

Failure Rate Summaries

Analysis of Candidate Performance by Test Section

Analysis of Failure Rates by Group Assignment

Analysis of Mean Scores by Procedure/Examination Part

Examiners' Score Agreement Summary

Frequency of Rating Assignments

Correlation of Treatment Selection with Restorative Results

Frequency of Penalty Assignments

Annual Schools Report

- Schools are provided with data regarding their performance annually
- Schools are provided individual candidate performance after each examination series.
- School identities are coded so that each school may compare their performance confidentially
- Performance data for each area of examination content is analyzed and presented
- By procedure
- By individual criterion

Examiner Profiles

- Data is collected for each examiner and compiled into profiles providing information to the examiners regarding their evaluations.

Summary of Total Number of Evaluations per Dental Examiner

Summary of Examiner Agreements for each Examination/Procedure

Percentage Rating Level Assigned per Procedure

Summary of Examiner Agreements & Disagreements across all Procedures

Peer Evaluations

- This information is utilized to monitor examiner performance

ADEX Dental Hygiene Examination

The following is a brief description of the ADEX Dental Hygiene Examination.

The ADEX Dental Hygiene Examination was designed with three goals in mind. We strive to maintain an examination that is:

1) Candidate friendly
2) Safe and complete treatment for the patient
3) Reliable, defensible and fair.

The Examination in Dental Hygiene consists of two Examinations and each takes place at different times. The Computer Simulated Clinical Examination (CSCE) is a computer based examination, approximately 2 hours in length, and usually takes place on one day appointments at a testing center. The Patient Treatment Clinical Examination (PTCE) is approximately 4 hours in length, scheduled at a clinical examination site. A score of 75 or more is required to pass each examination.

The ADEX Dental Hygiene Examination has the following requirements for tooth and surface selection:

- 12 surfaces of subgingival calculus on 6 to 8 permanent teeth charted
- Each tooth with at least one surface of calculus must be within a primary quadrant
- 8 of the 12 surfaces are premolars and molars
- 5 of these surfaces must be posterior proximal surfaces
- 3 of these proximal surfaces must be on molars
- All posterior teeth must be within 2mm of another tooth
- Only one distal surface of a 2nd or 3rd terminal molar may be used as one of the molar surfaces.

An "Alternative Selection Process" was implemented for those candidate's whose patient's primary quadrant does not meet the tooth or surface requirement. A candidate may choose up to 4 contiguous posterior teeth in a second quadrant as an alternate.

Another important requirement is that **all** teeth in the primary quadrant and/or the alternative selection (if chosen) must be **completely treated** (defined as the removal of all supra and subgingival calculus and coronal plaque/stain). This is an effort to be "complete" for the patient's dental health and well-being.

The inclusion of the anterior and posterior pocket measurement assignment **within** the primary quadrant or alternative selection.

Continuing our efforts to be candidate friendly, the Clinic Floor Examiner (CFE) reviews the medical history, consent form and treatment selection for errors. The CFE will also select the anterior and posterior tooth for the Pocket Measurement Assignment and instruct the candidate to probe the 2 assigned teeth *before* sending the patient to the evaluation station for pre-treatment evaluation.

Each of the 3 pre-treatment examiners probe the 2 assigned teeth for pocket measurement documenting their findings.

With a 92% pass rate on the first attempt of the ADEX Dental Hygiene Examination in 2010, the 3 most common reasons preventing success were inadequate calculus removal, deficient calculus detection and insufficient pocket qualification.

The ADEX Dental Hygiene Examination continues to provide the students with a candidate friendly examination, allowing safe and complete treatment for the patient and an assurance to the states that our ADEX Dental Hygiene Examination is reliable, defensible and fair.

For additional info on ADEX contact:

ADEXOFFICE@aol.com

(503) 724-1104

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AMERICAN BOARD OF DENTAL EXAMINERS, INC.

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9th ADEX House of Representatives
November 10, 2013

PROCEEDINGS

Call to Order and Introductions: President Bruce Barrette called to order the 9th meeting of the ADEX House of Representatives at 8:10 a.m. on Sunday, November 10, 2013 in the Signature Ballroom, Doubletree Hotel, Rosemont, IL.

Roll Call: President Barrette introduced the members of the House of Representatives: Dentist/Administrator Representatives: Mr. Maulid Miskell, CO; Dr. Mark Baird, HI; Dr. Rick Thiriot, NV; Dr. Patricia Parker, OR; Dr. Scott Houfek, WY; Dr. Leo Huck, WI; Dr. Dennis Manning, IL; Dr. Stephen Pritchard, IN; Dr. William Wright, MI; Dr. Jacinto Beard, OH; Dr. George Martin, AR; Dr. Katherine King, KY; Dr. Charles Holt, Jr., TN; Dr. Z. Vance Morgan, SC; Dr. Evelyn M Rolon, VA; Dr. Richard "Duff" Smith, WV; Dr. Maurice Miles, MD; Dr. Lisa Deem, PA; Dr. Martin Rutt, CT; Dr. Jezzelle Sonnier, DC; Dr. Arthur McKibbin, Jr, NH; Dr. Peter DeSciscio, NJ; Dr. Russell Chin, RI; Dr. Milton Glicksman, MA; Dr. David Averill, VT; Dr. Thomas Willis, AL; Dr. Jeffery Hartsog, MS; Dr. David Howdy, NC; Dr. Augusto Cesar Garcia-Aguirre, PR; Dr. Wade Winker, FL; Dental Hygiene Representatives: Mary Davidson, RDH, OR, District 2; Ms. Nan Kosydar Dreves, RDH, WI, District 4; Ms. Lynda Sabat, RDH, OH District 5; Ms. Mary Ann Burch, RDH, KY District 6; Cheryl Bruce, RDH, MD, District 7; Sibyl Gant, RDH, DC, District 8; Ms. Shirley Birenz, RDH, NJ, District 9; Ms. Karen Dunn RDH, MA, District 10; Ms. Janet Brice McMurphy, RDH, MS, District 11; Ms. Irene Stavros, RDH, FL, District 12; Consumer Representatives: Ms. Lisa Wark, NV, District 2; Ms. Judith Ficks, WI, District 4; Ms. Clance LaTurner, IN, District 5; Mr. Allan Horwitz, PA, District 7; Ms Lynn Joslyn, NH, District 9; Ms. Diane Denk, ME District 10; Ms. Vicki Campbell, FL, District 12. There were 48 out of 53 State Board, District Hygiene and Consumer Representatives present.

President Barrette introduced ADEX officers, Dr. Stan Kanna, HI, Vice-President; Dr. William Pappas, NV, Secretary, Dr. Robert Jolly, AR, Treasurer, and Dr. Guy Shampaine, MD, Immediate Past President.

President Barrette also introduced representatives from Associate Member organizations: Dr. Hal Fair, Trustee representing the American Dental Association (ADA); Ms. Jiwon Lee, representing the American Dental Students Association (ASDA); Dr. Peter Robinson, American Dental Education Association (ADEA); Dr. William Judson, representing the National Dental Board of Canada(NDEB); Dr. Gerard Dillion, representing the National Board of Medical Examiners (NBME) and Mr. David Johnson representing the Federation of State Medical Boards, (FSMB).

ADEX Board of Directors Members in attendance: Dr. Keith Clemence, WI, District 4; Dr. Michelle Bedell, SC, District 6; Dr. John Reitz, PA, District 7; Dr. Robert Ray, DC, District 8; Dr. Richard Dickinson, VT, District 10; Mr. James McKeman, RDH, NV, Hygiene Member.

Additional Guests: Ms. Kathleen White, Executive Director-SRTA, VA, Dr. Marc Muncy, AR, President-Elect-SRTA; Dr. H.R. Marshall, WV, President-SRTA; Dr. David Perkins,Vice-Chairman-NERB; Dr. Ellis Hall, NERB, MD; Dr. Delma Kinlaw, Executive Director-CITA; Dr. Chip McVea, President-CITA; Dr. Hal Haering, AZ, Chair-ADEX QA Committee and Ms. Leah Diane Howell, Executive Director Mississippi Dental Board.

Also in attendance: Patrick D. Braatz, ADEX volunteer Administrator

Adoption of Agenda: Dr. Dennis Manning, IL moved and Ms. Diane Denk, ME seconded a motion to adopt the agenda with the proviso that the President could reorder items if necessary. The motion passed by general consent.

Adoption of Proceedings of the 8th ADEX House of Representatives, November 11, 2012

Dr. Dennis Manning, IL, moved and Dr. Arthur McKibbin, NH seconded a motion to adopt the Proceeding of the 8th ADEX House of Representatives, November 11, 2012. The motion passed by General Consent.

Presentations from Associate Members

ADA – Dr. Hal Fair gave greeting from the ADA

ADEA - Dr. Robinson ADEA had no official report.

ASDA – Ms. Jiwon Lee, gave greetings from the ASDA

NBME- Dr. Gerard Dillion had no official report

NDEB – Dr. William Judson had not official report.

FSMB - Mr. David Johnson had no official report.

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President's Report

Dr. Bruce Barrette, President of ADEX gave the following report:

I am pleased to stand before you today and talk about ADEX's past year.

We continue to refine and improve our dental examination. Most notably, the perio scaling exercise is now optional and there will be a reduction of the four scoring categories to three. Also, we will be reporting passing scores as "75 and above". Our radiology protocols are being re-evaluated to conform to the newest standards. Work on common manuals is being completed and the DSCE has been psychometrically reviewed with revisions in its length and a greater emphasis on periodontics.

Improving the calibration exercises to make them relevant as well as increasing our pool of slides so there aren't duplicates at every site has proven to be challenging. As a result, we have brought aboard Dr. Howard Strassler from the Maryland dental school to be our lead person on this project. We have seen some of his past work and we are confident that he can deliver an outstanding product.

The ADEX Dental Hygiene Committee has been busy continuing to work towards a national exam that is fair, psychometrically based, and efficient for hygienists to enjoy portability upon graduation. During the course of three conference calls in preparation for this meeting, the committee has been creating a common manual that can be used by all of the testing agencies. The 2015 commitment to put the dental hygiene examination on an electronic platform has been and continues to be a key guiding principle in all of the committee's discussions.

It was decided, following a vote by the 3rd and 4th year students at the University of Illinois-Chicago that ADEX will test there again after a hiatus of a number of years. At the same time, after testing a number of their students at Midwestern Dental School, we will be examining at A. T. Still Dental School in Phoenix Arizona for the first time.

This past year began with ADEX welcoming SRTA into our family. A lot of time and effort on both the part of SRTA and ADEX went into assisting SRTA to administer the ADEX examination. I want to publicly thank all the members of SRTA for their patience and professionalism during this adjustment period.

Earlier this week in New Orleans, our fellow examiner and member of the ADEX dental hygiene exam committee, Dr. Maxine Feinberg was chosen by the American Dental Association to be their next President. We wish her all the best with this new endeavor.

I would be remiss if I didn't mention our Executive Director, Patrick Braatz who not only does all the preparations for this Annual Meeting but also takes care of all the administrative details of ADEX during the year. Some of you may not know, he does this all as a volunteer and then ADEX contributes a modest amount to a charity of his choice. We can't thank him enough for all he does for ADEX.

The Council of Interstate Testing Agency (CITA) was one of the founders of ADEX and although they have been administering their own exam for a number of years there are a lot of similarities in our two exams. In August, we were approached by members of CITA and had a number of informal and formal discussions, which resulted in CITA applying for membership. At the same time, the state boards of Alabama, North Carolina and Puerto Rico applied for membership in ADEX. On September 25, the ADEX Board of Directors met and approved those applications. We are also hopeful that when the state board of Louisiana meets in December, they will vote to become a member of ADEX.

CITA's decision to participate in this process will continue to enhance the ADEX process and ensure that the dental profession's input is as comprehensive as possible. All of us, at ADEX, welcome CITA to ADEX and look forward to working with them in the upcoming years.

With the addition of CITA, it will now be possible for close to 70% of graduating dental students to take one examination in their home school and be accepted for licensure in 46 licensing jurisdictions in the United States. This includes 44 states with the anticipated participation of Louisiana along with Puerto Rico and the District of Columbia. We currently are testing in 38 dental schools and 121 dental hygiene schools and are the largest and most accepted dental licensure examination in the nation.

Presentation from:

Dr. Robert Faiella, DMD, Immediate Past President of the American Dental Association gave a report on his experiences as an ADEX Examiner.

Presentation from:

Dr. Guy Shampaine, Immediate Past President ADEX, gave a report on his recent presentation at the Conference of Licensure in Korea.

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Dr. Stephen Klein, Gansk & Associates, ADEX Psychometrician:

Dr. Barrette announced that Dr. Stephen Klein was not able to attend the meeting due to a medical condition and the Technical report will be completed in a few weeks and sent to the participants of the ADEX Meetings and made a part of the Annual Report and the distributed to the member states.

Dr. Scott Houfek, Chair - ADEX Dental Examination Committee - Dental Examination Overview

Dr. Scott Houfek, Chair of the Dental Examination Committee Reported on the following items that were approved and are being recommended by the ADEX Dental Examination Committee.

The following are the recommendations to the ADEX House of Representatives regarding the Dental Examination.

2014 Dental Examination Recommendations:

There are 6 changes that are being recommended to the ADEX House of Representatives Meeting for approval for the 2014 exam.

- The radiology recommendations were approved.
- No sharing of class III patients.
- Allow one lesion to be treated on anterior tooth.
- The new medical history was approved.
- All exposures to be processed at the express chair.
- Remove the phrase" damage to the patient" wherever it appears.

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Dr. Peter DeSciciso, NJ moved and Dr. Rick Thiroit, NV seconded a motion to accept the Dental Examination Committee Report. Motion approved by general consent.

Nan Kosydar Dreves, RDH, MBA - Chair ADEX Dental Hygiene Exam Committee - Dental Hygiene Examination Overview

Nan Kosydar Dreves, RDH, MBA presented the report of the Dental Hygiene Examination Committee meeting which was held on Friday and Saturday, November 8-9, 2013. The following recommendations were made by the examination committee:

The following are the recommendations to the ADEX House of Representatives regarding the Dental Hygiene Examination for 2013 and 2014

No Changes for the 2014 Dental Hygiene Examination

2015 Dental Hygiene Examination Recommendations:

- All changes made to the manual approved for 2015 and to adopt the blueprinted electronic format.

Dr. Patricia Parker, OR moved and Ms Judith Ficks, WI seconded a motion to accept the Dental Hygiene Examination Committee Report. Motion approved by general consent.

Treasurer Report and ADEX Budget

Dr. Robert Jolly, ADEX Treasurer reported that the current ADEX Fund Balance is $102,553.24

Dr H. Warren Whitis, AR moved and Mary Ann Burch, RDH, MD seconded motion to accept the Treasurer's Report. Motion passed by general consent.

Mr. Patrick Braatz on behalf of the ADEX Budget Committee presented the 2013 – 2014 ADEX Budget which has been recommended by the ADEX Budget Committee and has been recommended to the ADEX House of Representatives by the ADEX Board of Directors. The 2013 - 2014 Budget is Revenue of $280,000 which is paid by NERB, SRTA CITA and proposed expenses of $315,000.

Mary Ann Burch, RDH, MD moved and Dr. Dennis Manning, IL seconded a motion to approve the 2013 – 2014 ADEX Budget. Motion passed by general consent.

Business Session

Proposed Bylaws Amendments: Dr. Robert Ray, Chair of the By-Laws Committee reported on the recommended changes to the ADEX by-Laws as suggested by the ADEX Corporate Counsel.

Dr. Robert Ray, DC moved, seconded by Dr. Dennis Manning, IL to approve the recommended ADEX By-Law changes. The motion approved by General Consent.

Nomination of ADEX Officers for 2013 – 2014: Dr Barrette passed the gavel to Dr. Shampaine, Immediate Past President to accept the nominations for the Officers of ADEX.

Dr. Leo Huck, WI moved and Dr. Scott Houfek, WY seconded a motion to nominate Dr. Bruce Barrette, WI as President of ADEX for 2013-2014 term. There were no other nominations. The motion passed by general consent.

Dr. Mark Baird, HI moved and Ms. Sibyl Gant, DC seconded a motion to nominate Dr. Stanwood Kanna as Vice-President of ADEX for 2013-2014 term. There were no other nominations. The motion passed by general consent

Dr. Patricia Parker, OR moved and Dr. Mark Baird, HI seconded a motion to nominate Dr. William Pappas, NV as Secretary of ADEX for 2013-2014 term. There were no other nominations. The motion passed by general consent.

Dr. George Martin, AR moved and Ms. Judith Ficks, WI seconded a motion to nominate Dr. Robert Jolly, WI as President of ADEX for 2013 - 2014 term. There were no other nominations. The motion passed by general consent.

Dr. Shampaine, Immediate Past President of ADEX returned the gavel to Dr. Bruce Barrette, President.

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Nomination of Consumer Board of Directors Member

Ms. Judith Ficks, WI moved and Dr. Dennis Manning, IL seconded a motion to nominate Ms. Lisa Wark of Nevada as a Consumer Member to the ADEX Board of Directors for a three year term. The motion passed by general consent.

Nomination of Dental Hygiene Board of Directors Member:

Ms. Nan Kosydar Dreves, RDH, WI, moved and Mary Davidson, RDH, OR seconded a motion to nominate James "Tuko" McKernan, RDH, of Nevada as a Dental Hygiene Member to the ADEX Board of Directors. The motion passed by general consent.

Caucuses: The House broke into district caucuses.

District Elections: The following are the caucus election results and include new appointees as well as re-elected representatives:

District 2
Patricia Parker, DDS, OR, District Director continues as Director Term Expires 2015 HOR.
Mary Davidson, RDH, OR, House District RDH Representative Term 2014 HOR.
Matt Tripp, RDH, OR, RDH Examination Committee Member, Term 2016, HOR.
Lisa Wark NV, Consumer Representative Term 2014 HOR.
Dr. Rick Thiriot, NV, District Educator Dental Exam Committee, Term 2016 HOR.

District 4:
Dr. Keith Clemence, WI, District Director continues as Director Term Expires 2015 HOR.
Nan Kosydar Dreves, RDH, MBA, House District RDH Representative Term Expires 2014 HOR
Beth Clemence, RDH Examination Committee Member, Term Expires 2015 HOR
Judy Ficks, RDH, Consumer Member, Term Expires 2014 HOR
Dr. Leo Huck, District Educator Dental Exam Committee, Term Expires 2016 HOR

District 5:
Dr. Dennis Manning IL, District Director for Term to Expire 2016 HOR
Lynda Sabat, RDH, OH, House District RDH Representative, Term to Expire 2014 HOR
Laverne Whitemore, RDH, PA RDH Examination Committee Member, Term to Expire 2016 HOR
Ms. Clance LaTurner, IN, Consumer Representative, Term to Expire 2014 HOR
Dr. Peter Yaman, MI, Educator Dental Exam Committee, Term to Expire 2014 HOR

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District 6: Dr. Michelle Bedell, SC, District Director, Term to Expire 2014 HOR
Sherie Williams Barbare, RDH, SC, House District RDH Representative, Term to Expire 2014 HOR
Mary Ann Burch, RDH, WV, RDH Examination Committee Member, Term to Expire 2016 HOR
Bettye Richert, TN, Consumer Representative, Term to Expire 2014 HOR
Dr. Rick Archer, VA, Educator Dental Exam Committee Member, Term to Expire 2016 HOR

District 7: Dr. John Reitz, PA, District Director, Term to Expire 2015 HOR
Cheryl Bruce, R.D.H., MD, House District RDH Representative, Term to Expire 2014 HOR
Mariellen Brickley-Raab, RDH, PA, RDH Examination Committee Member, Term to Expire 2014 HOR
Allan Horwitz, Esq., PA, Consumer Representative, Term to Expire 2014, HOR
Dr. Uri Hangorsky, DDS, PA, Educator Dental Exam Committee, Term to Expire 2014 HOR

District 8 Dr. Martin Rutt, CT District Director, Term to Expire 2016 HOR
Sybil Gant, RDH, DC, House District RDH Representative, term to Expire 2014 HOR
Sybil, RDH, DC, RDH Examination Committee Member, Term to Expire 2016 HOR
TBD Consumer Representative:
Dr. John Bailey, DC, Educator Dental Exam Committee, Term to Expire 2014 HOR

District 9: Dr. Arthur Andy McKibbin, NH, District Director, term to Expire 2016 HOR
Shirley Birenz, RDH, NJ, House District RDH Representative, Term to Expire 2014 HOR
Shirley Birenz, RDH, NJ RDH Examination Committee Member, term to Expire 2014 HOR
Ms. Lynn Joslyn, NH Consumer Representative, Term to Expire 2014 HOR
Dr. Marc Rosenblum, NJ, Educator Dental Exam Committee, Term to Expire 2014 HOR

District 10: Dr. Richard Dickinson, VT, Term to Expire 2014 HOR
Karen Dunn, RDH, MA, House District RDH Representative, Term to Expire 2014 HOR
Karen Dunn, RDH, MA, RDH Examination Committee Member, Term to Expire 2014 HOR
Diane Denk, ME, Consumer Representative, Term to Expire 2014 HOR
Dr. Steven DuLong, MA, Educator, Dental Exam Committee, Term to Expire 2016 HOR

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District 11: Dr. Jeffery Hartsog, MS, District Director, Term to Expire 2015 HOR
Carla Stack, RDH, NC, House District RDH Representative, Term to Expire 2014 HOR
Janet Brice McMurphy, RDH, MS, RDH Examination Committee Member, Term to Expire 2015 HOR
Jim Hemby, NC, Consumer Representative, Term to Expire 2014 HOR
Dr. Larry Breeding, MS Educator Dental Exam Committee, Term to Expire 2015 HOR

District 12: Dr. Wade Winker, FL, District Director, Term to Expire 2014 HOR
Irene Stavros, RDH, FL, House District RDH Representative, Term to Expire 2014 HOR
Irene Stavros, RDH, FL, RDH Examination Committee Member, Term to Expire 2014 HOR
Vicki Campbell, FL, Consumer Representative, Term to Expire 2014 HOR
Dr. Robert Perdomo, FL, Educator Dental Exam Committee, Term to Expire 2016 HOR

Election of Consumer Board of Directors Member:

Ms. Judith Ficks, WI moved and Dr. Dennis Manning, IL seconded a motion to have the Secretary cast a unanimous ballot for Ms. Lisa Wark of Nevada as a Consumer Member to the ADEX Board of Directors for a three year term. The motion passed by general consent.

Election of Dental Hygiene Board of Directors Member:

Ms. Nan Kosydar Dreves, RDH, WI, moved and Mary Davidson, RDH, OR seconded a motion to have the Secretary cast a unanimous ballot for James "Tuko" McKernan, RDH, of Nevada as a Dental Hygiene Member to the ADEX Board of Directors. The motion passed by general consent.

Approval of 2014 Dental Examination:

Dr. Arthur McKibbins, NH moved and Dr. Mark Baird. HI, seconded a motion to approve the dental examination as recommended by the Board of Directors. The motion passed by general consent.

Approval of 2014 Dental Hygiene Examination:

Ms. Cheryl Bruce, RDH, MD moved and Dr. Dennis Manning, IL seconded a motion to approve the dental hygiene examination as recommended by the Board of Directors. Motion passed by general consent.

Future Meeting Dates

The 10th ADEX House of Representatives Meeting will be held Sunday, November 9, 2014 at the Doubletree Hotel O'Hare/Rosemont, IL

Adjournment: Ms. Judith Ficks, WI moved and Ms. Mary Davidson, OR seconded a motion for adjournment. The motion passed by general consent. The meeting was adjourned at 11:25 a.m.

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10th Annual Meeting

SAVE THE DATES

NOVEMBER 7, 8, 9, 2014

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ADEX Quality Assurance Committee

ADEX Dental Examination Committee & Subcommittees

ADEX Dental Hygiene Examination Committee

ADEX Board of Directors

ADEX Reception

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DoubleTree Hotel O'Hare – Rosemont, IL

Official information will be sent in July 2014

Questions contact ADEXOFFICE@aol.com

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES OF REGULATORY-LEGISLATIVE COMMITTEE
May 2, 2014

TIME AND PLACE: The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order at 1:00 p.m., on May 2, 2014, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia.

PRESIDING: Jeffrey Levin, D.D.S., Chair

MEMBERS PRESENT: Charles E, Gaskins, III., D.D.S.
Melanie C. Swain, R.D.H.

MEMBERS ABSENT: Evelyn M. Rolon, D.D.S.

OTHER BOARD MEMBERS: Al Rizkalla, D.D.S.
Bruce S. Wyman, D.M.D.

STAFF PRESENT: Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Huong Q. Vu, Operations Manager

OTHERS PRESENT: Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

ESTABLISHMENT OF A QUORUM: With three members present, a quorum was established.

PUBLIC COMMENT: Steven Lindauer, DMD, Chair of VCU Department of Orthodontics, addressed the use of dental assistants in orthodontic practice and provided a list of duties for reference by the Board.

L. Warren West, DDS, of the Virginia Society of Oral Maxillofacial Surgeons, commented that the draft permit holder office inspection form does not ask the dentist and staff to demonstrate the ability to handle emergency situation and that the people who conduct the inspection should be clinicians who are knowledgeable about sedation.

Ms. Reen introduced Jamie Hoyle who is the new DHP Chief Deputy Director.

APPROVAL OF MINUTES: Dr. Levin asked if Committee members had reviewed the February 7, 2014 minutes. Dr. Gaskins moved to accept the minutes. The motion was seconded and passed.

STATUS REPORT ON REGULATORY ACTIONS:

Ms. Yeatts reported that the:

- Periodic Review of proposed regulations to establish four chapters are under review at the Secretary's office.
- Sedation and Anesthesia final regulations were approved by the Governor and will be effective on May 7, 2014.

Final Report of 2014 General Assembly (GA) - Ms. Yeatts stated this report includes the bills addressing health professions that passed this year, with one exception. She said that SB647 which would require DMAS to create a teledentistry pilot program for eligible school-age children was continued to 2015 in Appropriations Committee. She added that SB294 requires all prescribers, including dentists, to register with the Prescription Monitoring Program.

FEE SPLITTING:

Ms. Yeatts stated that the Committee asked her to develop a proposal to address concerns advanced through public comment about fee splitting between dentists and with third parties. She reviewed her findings in the following materials:

- American Dental Association (ADA) Principles of Ethics and Code of Professional Conduct
- ADA Legal Issues in Marketing a Dental Practice: Referral Gifts and Groupon Discounts
- New York Law Journal article on Internet Discounts On Health Care Services: Strictly Illegal (January 24, 2012, Volume 214 – NO. 7)
- California Business and Professions Code Sections 650-657
- Virginia Board of Dentistry Guidance Document 60-15
- Virginia Board of Medicine Code and Regulatory Provisions
- Draft Legislative Proposal for a Prohibition on Fee-Splitting or Rebates

Ms. Yeatts noted that currently there is nothing in the statue specific to fee splitting so if the Committee sees the need to forward this legislatively, the Board needs to act at its June meeting in order to meet the proposal deadline for the 2015 General Assembly.

Dr. Wyman stated that in Northern VA, it is a common practice for surgeons to provide restorative components to dentists for patients receiving implant treatment. He asked if this practice would be prohibited by the proposal and noted that the benefit is that the components are the appropriate size. He added patients may not be aware of this practice and may end up paying twice for the components. Dr. Rizkalla said that in his opinion this practice hasd become a financial incentive for patient referrals.

Dr. Wyman stated that he is also concerned about the practice of annual holiday gifts given by specialists to general dentists, the amount or value of which is frequently related to the number of patients referred. Ms. Yeatts commented that if a dentist receives a gift based on the number of referrals then the dentist is receiving a rebate.

Ms. Reen asked Ms. Yeatts if there is provision on inducement in her research and whether the Committee needs to add this language to the discussion draft. Ms. Yeatts stated that CA does have inducement language in its Code. Ms. Yeatts then suggested to add the following language to the discussion draft "***accept or tender compensation or inducement whether in the form of money or otherwise***" right after "*No dentist shall directly or indirectly accept or tender a rebate,*" By consensus, the Committee agreed.

Dr. Gaskins moved to recommend the proposed draft legislation to include inducement for consideration by the Board on June 13, 2014 meeting. The motion was seconded and passed.

PRACTICE OWNERSHIP:

Ms. Reen stated that the Committee is charged to work with a Regulatory Advisory Panel (RAP) to develop a proposal to address concerns advanced through public comment and through disciplinary cases regarding:

- Sole proprietorships
- Large corporate dental practices, and
- Practice management companies.

She added that the following materials are provided to facilitate discussion:

- A historical provision of law on what constitutes the practice of dentistry
- Excerpts from the Code of Virginia
- A policy statement adopted by the Tennessee Board of Dentistry
- The Department of Taxation's listing of business entity types
- The State Corporation Commission's listing of entity types and categories
- Congressional Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program
- North Carolina's Law on Dental Management Arrangements, and
- Texas' Law and Regulations on Control of Dental Practice

Ms. Reen asked for guidance on the goals or concepts to be addressed with the the RAP to facilitate invitations to the appropriate agencies for technical assistance to assist the Board in identifying a strategy to address the concerns which is within the Board's scope of authority.
After discussion of the materials, by consensus, the Committee decided that the Board wants the authority to address ownership and practice management organizations. It agreed to use the Texas law and regulations as the model for discussion.

PERMIT HOLDER OFFICE INSPECTIONS:

Revised Inspection Form – Ms. Reen stated that, with the final sedation and anesthesia permit regulations becoming effective on May 7, 2014, it is time to institute the planned periodic inspections. She noted that board and enforcement staff developed the revised form and draft guidance document for discussion. She commented that this form is a multi-use form which can be

used for complaint investigations, compliance cases, and periodic inspections for permit holders. She asked the Committee to give direction to staff for developing the documents for presentation to the Board. Ms. Reen noted that the inspections will be conducted by DHP inspectors or investigators who will collect the information and forward the inspection results to the Board for review.

Several members of the public objected to the multi-use form as being too intrusive and unfair to permit holders. They also expressed concern about using DHP staff to conduct the inspections and that the form does not address emergency preparedness. The Committee discussed these concerns with them. During the discussion, Ms. Reen said the Board has the authority to look at the whole environment in order to protect the public, that review of emergency preparedness should be added to the form and that many of DHPs inspectors are health profession licensees.

Dr. Gaskins moved to forward the draft form with the addition of emergency preparedness to the Board for consideration. The motion was seconded and passed.

Guidance Document (GD) - Ms. Reen stated that the proposed guidance document addresses the scope and implementation of the periodic office inspections for permit holders. She added that the draft GD is presented for review and action by the Committee.

Dr. Gaskins moved to forward it to the Board for consideration on June 13, 2014 meeting. The motion was seconded and passed.

NEW BUSINESS:

Dr. Gaskins proposed a draft guidance document to address the record keeping requirements for endodontic root canal treatment. He stated that he has reviewed and heard numerous Board cases where root canal treatment and documentation has been of great concern. He added that his draft has been reviewed by seven board certified endodontists who confirmed these standards for endodontic treatment. He noted that the following optional items should be deleted from the list:

- Access Notes/Difficulties, Intra-Coronal Findings, etc.
- State of Pulp
- Trail Length (s)/Per Canal.

Dr. Gaskins agreed to include introductory information to the guidance document. By consensus, the Committee agreed to forward the draft to the Board for consideration at the June 13, 2014, meeting.

NEXT MEETING:

The dates of August 15 or 22, 2014 were identified as options for the next Committee meeting. Ms. Reen said the Committee members will be polled for availability. All agreed.

ADJOURNMENT:

With all business concluded, Dr. Levin adjourned the meeting at 3:41 p.m.

Jeffrey Levin, D.D.S., Chair

Date

Sandra K. Reen, Executive Director

Date

Virginia Board Business Meeting Materials On June 13, 2014 Part 2

P84-P144

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions (As of June 4, 2014)**

Board of Dentistry

Chapter		Action / Stage Information
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30 [Action 3252] Final - *At Secretary's Office for 65 days*

Agenda Item: DRAFT Legislation for the 2015 Session of the General Assembly

Included in the agenda package:

A copy of the ADA Principles of Ethics and Code of Professional Conduct on fee-splitting

A copy of "Legal Issues in Marketing a Dental Practice: Referral Gifts and Groupon Discounts," message from the ADA Legal Division

A copy of an excerpt from the Dental Practice Act in Illinois

A copy of Virginia Board of Dentistry Guidance Document 60-15 (See Financial Transactions)

A copy of laws and regulations on fee-splitting for the Virginia Board of Medicine

A copy of DRAFT legislation which includes the language recommended by the Regulatory/Legislative Committee and an alternative version redrafted after the Committee meeting

Action:

Consideration of the Committee recommendation for 2015 legislation on fee-splitting

American Dental Association

PRINCIPLES OF

Ethics

AND

CODE OF

Professional Conduct

With official advisory opinions revised to April 2012.

ADA American Dental Association®

4.E. REBATES AND SPLIT FEES.
Dentists shall not accept or tender "rebates" or "split fees."

ADVISORY OPINION

4.E.1. SPLIT FEES IN ADVERTISING AND MARKETING SERVICES.
The prohibition against a dentist's accepting or tendering rebates or split fees applies to business dealings between dentists and any third party, not just other dentists. Thus, a dentist who pays for advertising or marketing services by sharing a specified portion of the professional fees collected from prospective or actual patients with the vendor providing the advertising or marketing services is engaged in fee splitting. The prohibition against fee splitting is also applicable to the marketing of dental treatments or procedures via "social coupons" if the business arrangement between the dentist and the concern providing the marketing services for that treatment or those procedures allows the issuing company to collect the fee from the prospective patient, retain a defined percentage or portion of the revenue collected as payment for the coupon marketing service provided to the dentist and remit to the dentist the remainder of the amount collected.

Dentists should also be aware that the laws or regulations in their jurisdictions may contain provisions that impact the division of revenue collected from prospective patients between a dentist and a third party to pay for advertising or marketing services.

Section 5 PRINCIPLE: VERACITY ("truthfulness"). The dentist has a duty to communicate truthfully.

This principle expresses the concept that professionals have a duty to be honest and trustworthy in their dealings with people. Under this principle, the dentist's primary obligations include respecting the position of trust inherent in the dentist-patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity.

CODE OF PROFESSIONAL CONDUCT
5.A. REPRESENTATION OF CARE.
Dentists shall not represent the care being rendered to their patients in a false or misleading manner.

ADVISORY OPINIONS

5.A.1. DENTAL AMALGAM AND OTHER RESTORATIVE MATERIALS.
Based on current scientific data, the ADA has determined that the removal of amalgam restorations from the non-allergic patient for the alleged purpose of removing toxic substances from the body, when such treatment is performed solely at the recommendation of the dentist, is improper and unethical. The same principle of veracity applies to the dentist's recommendation concerning the removal of any dental restorative material.

5.A.2. UNSUBSTANTIATED REPRESENTATIONS.
A dentist who represents that dental treatment or diagnostic techniques

LEGAL ISSUES IN MARKETING A DENTAL PRACTICE: REFERRAL GIFTS AND GROUPON DISCOUNTS

Message from the ADA Legal Division
October 7, 2011

ADA American Dental Association®
America's leading advocate for oral health

ADA American Dental Association®

211 East Chicago Avenue
Chicago, Illinois 60611

T 312.440.2500
F 312.440.7494
www.ada.org

Date: October 7, 2011

To: ADA Constituent Executive Directors

From: ADA Legal Division

Subject: Legal Issues in Marketing a Dental Practice: Referral Gifts and Groupon Discounts[1]

QUESTION PRESENTED

Whether a dentist's adoption of any of the following practices creates potential legal concerns:

(a) Offering and awarding gifts[2] to existing patients in exchange for new patient referrals ("referral gifts")?

(b) Offering and awarding Groupon[3] discounts to new or existing patients?

(c) Advertising Groupon or other discounts in connection with dental services?

EXECUTIVE SUMMARY

Depending on (a) the state in which the dentist practices and (b) whether the dentist provides services payable under a federal health care program such as Medicare or Medicaid, a dentist may be prohibited under state and/or federal law from (i) offering and/or awarding referral gifts or (ii) offering and/or awarding Groupon discounts. Many states have regulations that prohibit or restrict the award of gifts as a means of soliciting patients, or prohibit fee splitting between a dentist and a third party. (A dentist utilizing Groupon to offer discounts to new patients will split a portion of the revenue generated from the Groupon promotion with Groupon.) In addition, the federal anti-kickback statute generally prohibits a dentist from offering or paying remuneration to induce a person to refer a patient that may be eligible for services under a federal health care program, including Medicare or Medicaid.

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[1] This memo is not intended to provide or offer legal or other advice and should not be relied upon for that purpose. To get appropriate legal advice, one should consult directly with a properly qualified attorney.

[2] For purposes of this memo, "gifts" include cash, gift cards, or other tangible items of value. It does not include discounts for services, for which different rules may apply.

[3] The analysis provided herein would be applicable to any company that provides similar services under a similar fee structure (e.g., LivingSocial).

A violation of the state regulations could result in the dentist's facing censure and reprimand, fines, suspension, and even license revocation, while a dentist violating federal law could be charged with a felony and subject to fines, imprisonment, and exclusion from federal health care programs.

The advertising of discounts may also raise concerns. Many states have dental advertising regulations that restrict the method of advertising discounts in connection with dental services. Some restrictions involve the form of the advertisement, while others involve the manner in which the discount and other fees are applied to a patient.

In addition, the terms of the dentist's contracts with third party payors may give rise to issues with the offer and award of referral gifts or Groupon discounts to patients. These contracts sometimes contain provisions requiring that fees submitted to the insurer reflect any rebates or reductions in the fees (or co-pays) charged to the patient, or that the dentist grant the insurer the best price that the dentist charges for a particular service (a "most favored nations" clause). In the first instance, giving a rebate to a patient after the service has been billed to the insurer may violate the contract; in the second, providing a discounted price to Groupon customers may breach the most favored nation provision (or perhaps require the dentist to offer the same discount to the insurer's patients, and perhaps even to rebate an equivalent per patient discount to the insurer).

Finally, the offer and award of referral gifts or Groupon discounts to patients may violate certain ADA ethical rules, including the rule prohibiting dentists from giving rebates and splitting fees.

ANALYSIS

1. Referral Gifts

A dentist may be prohibited under state and/or federal law from offering or awarding referral gifts to existing patients.

a. State Law

Many states have regulations that directly or indirectly prohibit or restrict the award of gifts as a means of soliciting dental patients. Some of these laws, such as those in Illinois and Texas, have a broad prohibition against such gifts. The Illinois Dental Practice Act (the "Illinois Act") makes it unlawful for any dentist to "advertise or offer gifts as an inducement to secure dental patronage",[4] and the rules of the Texas State Board of Dental Examiners (the "Texas Board Rules") make it illegal for a dentist to "offer, give, dispense, distribute or make available to any third party...any cash, gift, premium, chance, reward, ticket, item or thing of

[4] 225 ILCS 25/45.

value for securing or soliciting patients".[5] Under these regulations, even nominal gifts made to existing patients may be prohibited.[6]

Other state regulations have a more narrow prohibition against referral gifts. For example, while the New Jersey Board of Dentistry regulations include a general prohibition on offering or paying remuneration to third parties in exchange for a referral, that provision is tempered by the statement that "[n]othing contained in this section shall prohibit a dentist from providing a gift to a patient, or from providing a credit for dental services to a patient, provided the gift or credit does not exceed $25.00 in value".[7] Hence, referral gifts to existing patients having of value of $25.00 or less may be allowed under the New Jersey regulations.

In addition, some state regulations may be read to bar referral gifts to existing patients even though the regulations do not specifically mention "gifts" or "consideration". Under the Arizona Dental Practice Act, "unprofessional conduct" is defined to include the "giving or receiving . . . of rebates, either directly or indirectly".[8] While a referral gift such as movie tickets or a gift card may not typically be thought of as a rebate, a broad interpretation of the statute might treat such a gift as a means of helping to offset the patient's fees. Similarly, some statutes prohibit "fee splitting" for the referral of patients.[9] If a referral gift to an existing patient is interpreted as a method of dividing fees received from a new patient between the dentist and the existing patient, such gift would be prohibited under the fee-splitting laws.

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[5] Rule §108.60.

[6] See also, §29.1.b.3 and §29.1.b.12(e) of the New York Rules of the Board of Regents (unprofessional conduct includes "directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services" and "offer[ing] bonuses or inducements in any form other than a discount or reduction in an established fee or price for a professional service or product"); Section 650(a) of the California Business and Professions Code ("the offer, delivery, receipt, or acceptance by any person licensed under this division ... of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful").

[7] Chapter 13:30-8.13(d).

[8] Chapter 32-1201.21(k).

[9] See Section 23(5) of the Illinois Act (prohibiting the "[d]ivision of fees or agreeing to split or divide the fees received for dental services with any person for bringing or referring a patient"); Section 776.A(9) of the Louisiana Dental Practice Act (prohibiting the "[d]ivision of fees or other remuneration or consideration with any person not licensed to practice dentistry in Louisiana, or an agreement to divide and share fees received for dental services with any non-dentists in return for referral of patients to the licensed dentists, whether or not the patient or legal representative is aware of the arrangement"); Section 333.16221(d)(ii) of the Michigan Public Health Code (prohibiting "[d]ividing fees for referral of patients").

Accordingly, a dentist should carefully consider and seek guidance as to the application of state laws before offering and awarding referral gifts to patients. A violation by a dentist of the state dental board statute and regulations could result in the dentist's facing censure and reprimand, fines, suspension, and even license revocation. Note that compliance with state law would not absolve a dentist of exposure under federal law (and vice versa).

b. Federal Law

The federal anti-kickback statute ("AKS") prohibits any person from:

> " ... knowingly and willfully offer[ing] and pay[ing] any remuneration (including any kickback, bribe or rebate)...to any person to induce such person...to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program".[10]

The AKS can apply if even one purpose of the transaction is to generate referral(s) for such item or service. Prior to the enactment of the Patient Protection and Affordable Care Act in 2010 (the "Affordable Care Act"), some courts held that the AKS only applied if the defendant *knew* that the AKS prohibited offering or paying remuneration to induce referrals, and did so with the specific intent to disobey the law. However, the Affordable Care Act amended the AKS to make clear that the AKS does not require the government to prove actual knowledge of a "known legal duty" that was being breached, but only that the dentist intended to perform the act that violated the law.[11] In addition, the statute refers to payments that "may be" made under a federal health care program, so it is possible that a dentist who accepts Medicare or Medicaid patients may be found to have violated the AKS even if the payment for services at issue is not in fact made by a Medicare or Medicaid patient or out of Medicare or Medicaid funds.

Accordingly, a dentist who provides services payable by a federal health care program including Medicare or Medicaid should carefully consider the application of the AKS before offering and awarding referral gifts to patients.[12] A violation by the dentist of the AKS could result in the dentist being charged with a felony and subject to fines and imprisonment, in

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[10] 42 U.S.C. §1320a-7b(b).

[11] 42 U.S.C. §1320a-7b.

[12] There may also be an issue under the Civil Monetary Penalties Law (the "CMP") if the patient receiving the referral gift is a Medicare or state health care patient. Section 1128A(a)(5) of the CMP provides for the imposition of civil monetary penalties against any person who "gives something of value to a Medicare or state health care program beneficiary, including Medicaid, that the benefactor knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare or a state health care program, including Medicaid". However, "nominal" gifts of between $10 and $50 annually are generally allowed under the CMP.

addition to being excluded from federal health care programs, such as Medicare and Medicaid.

2. Groupon

Offering and awarding Groupon discounts by a dentist to new or existing patients may be prohibited under state or federal law.

a. State Law

As noted above, many states have regulations that prohibit fee splitting between a dentist and a third party. For example, the Michigan Public Health Code prohibits "[d]ividing fees for referral of patients".[13] When a dentist utilizes Groupon to offer discounts to new patients, the dentist generally splits the revenue generated from the promotion with Groupon (in fact, the fees are paid directly to Groupon, with Groupon then paying the dentist a percentage of the fees collected). This arrangement could be seen to violate state regulations prohibiting fee-splitting.

In addition, Groupon-type arrangements may also violate the other rules and regulations that prohibit dentists from providing referral gifts to existing patients. For example, as noted in Paragraph 1.a. above, under the Texas Board Rules a dentist may not offer or give cash to a third party for securing or soliciting patients. While the Texas Board Rules do have a "safe harbor" for remuneration for advertising, marketing or other services if the remuneration "is set in advance, is consistent with the fair market value of the services, and is not based on the volume or value of any patient referrals", the Groupon arrangement most likely would not meet the safe harbor requirements because Groupon's fees are not set in advance and are based on the volume or value of patient referrals. Accordingly, if Groupon is viewed under the rules as having secured or solicited patients for the dentist in exchange for cash, the Groupon arrangement may constitute a violation of such rules.[14]

A dentist may argue of course that Groupon is simply advertising or promoting the dentist's services, and is thus not referring or soliciting patients on behalf of the dentist. However, a dentist considering participation in Groupon may wish to wait until further guidance is provided by the states regarding this type of arrangement. In fact, the Oregon Board of Dentistry recently released a "Newsflash" announcing it "had preliminarily determined that [voucher systems for potential patients] may violate Oregon's unprofessional conduct rule which prohibits offering rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee or employer". The Board further advised that "until [such arrangements] can be fully reviewed by the Board, licensees proceed with caution and if they feel necessary seek legal counsel on this matter or contact the Board..."

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[13] Section 333.16221(d)(ii). See footnote 9 above for additional state regulations prohibiting fee splitting.

[14] See footnote 6 above for additional examples of state regulations prohibiting the payment of remuneration to third parties in exchange for patient referrals.

Accordingly, a dentist should carefully consider and seek appropriate guidance as to the application of state law before offering and awarding Groupon discounts to new or existing patients. A violation by a dentist of the state dental statutes and regulations might risk the possibility of censure and reprimand, fines, suspension, and even license revocation.

b. Federal Law

As described in Paragraph 1.b. above, the AKS prohibits any person from knowingly and willfully offering or paying cash to any person to induce the person to refer a patient for services for which payment may be made under a federal health care program. While the AKS does provide a safe harbor for payments by physicians to referral services such as professional societies or other consumer-oriented groups, the Groupon-type arrangement may not fit within the safe harbor, which requires that any payment from a participant to a referral service not be based on the volume or value of any referrals and must be based on the cost of operating the referral service.[15] On the other hand, the AKS should not be applicable if the Groupon discount is being offered solely for services that would not be covered by a federal health care program.

As under state law, a dentist may claim that Groupon is not referring patients on behalf of the dentist, but is instead simply advertising or promoting the dentist's services. Once again, however, the more prudent approach may be simply to wait to participate in Groupon until clear guidance is provided, by the federal government or the courts.

Accordingly, a dentist who provides services payable under a federal health care program should carefully consider the application of the AKS before offering Groupon discounts for covered services to new or existing patients. A violation of the AKS can be a felony and can subject an offender to fines, imprisonment, and exclusion from federal health care programs, such as Medicare and Medicaid.

3. Discount Advertising Regulations

Many states have regulations restricting the advertising of discounts in connection with dental services. Florida, for example, imposes the following disclosure requirements with respect to advertising of dental service discounts:

> (1) An appropriate disclosure regarding advertised fees is necessary to protect the public since there is no uniform code available which would enable a fair and rational selection based upon advertised fees.
> (2) Any advertisement containing fee information shall contain a disclaimer that the fee is a minimum fee only.
> (3) Any advertised fee for a dental service shall state a specified period during which the fee is in effect or that service shall remain available at or below the advertised fee for at least 90 days following the final advertisement for that service.

[15] 42 C.F.R. §1001.952(f).

> (4) Any dental service for which a fee is advertised shall be accompanied either by a description of that service using the exact wording for that service contained in the American Dental Association's "Code on Dental Procedures and Nomenclature"... or by the specific ADA Code number or numbers which accurately and fully describes the advertised dental service.[16]

In addition, Florida requires that the following statement be included in advertisements for discounted services in capital letters and clearly distinguishable from the rest of the text in the advertisement:

> THE PATIENT AND ANY OTHER PERSON RESPONSIBLE FOR PAYMENT HAS A RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT THAT IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED FEE, OR REDUCED FEE SERVICE, EXAMINATION, OR TREATMENT.

Similarly, in Indiana, advertisements of discount offers by dentists must disclose "the non-discounted or full price and the final discounted price", as well as the period during which the discount will be available.[17] Accordingly, a Groupon or other discount ad that does not contain the requisite language for satisfying applicable state dental advertising regulations may be in violation of the law.

In addition to restrictions on the form of the advertisement under state law, there may also be restrictions on the manner in which the discount and other fees are charged to a patient. The Illinois Act, for example, provides that "[d]entists may advertise or offer free examinations or free dental services; it shall be unlawful, however, for any dentist to charge a fee to any new patient for any dental service provided at the time that such free examination or free dental services are provided."[18] And New Jersey law states that "[s]ervices advertised as complimentary, free of charge or for a discounted fee shall be offered equally to all patients identified as eligible in the advertisement (for example "new patients"), regardless of the patient's third-party coverage."[19]

Accordingly, a dentist should carefully consider the application of, and seek appropriate guidance as to, the state dental advertising regulations before advertising for Groupon or

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[16] Fla. Admin. Code Ann. R. 64B5-4.003.

[17] 828 Ind. Admin. Code 1-1-18(d). See also Cal. Code Regs. Tit. 16 Section 1051 (advertising of discounted dental services must disclose the dollar amount of the non-discounted fee, the dollar amount of the discount fee (or the percentage of the discount), the length of time the discount is available, the specific groups who qualify for the discount, and any other applicable terms and conditions).

[18] 225 ILCS 25/45.

[19] N.J.A.C. 13:30-6.2.

other dental discounts. As in the case of the previously discussed statutes or regulations, a violation of the state dental statutes and regulations could result in censure and reprimand, fines, suspension, and even license revocation.

4. Insurance Contracts

The provision of referral gifts or discounts may also be problematic under the terms of the dentist's contracts with third party payors. These contracts may require that fees submitted to the insurer reflect any rebates or reductions in the fees (or co-pays) charged to the patient. In such case, if a rebate is given to a patient after the service has been billed to the insurer, the insurer may contend that the rebate effectively reduced the fees for the service and thus that the dentist's a claim is in violation of his or her contract (or even fraudulent). The rebate may also be viewed as violating Section 5.B. of the ADA Ethics Code, which provides that "[d]entists shall not represent the fees being charged for providing care in a false or misleading manner".

Further, if the insurance contract contains a "most favored nation" clause, that clause may be violated by referral gifts and Groupon discounts. A "most favored nation" clause generally provides that the dentist must grant the insurer the best price that the dentist charges for a particular service. The insurer could invoke such a clause to compel a dentist who has given a rebate or Groupon discount for a particular service to charge the reduced price for that service to all patients covered by the insurer, and even to rebate to the insurer amounts previously charged by the dentist in excess of the Groupon rate.

Accordingly, a dentist who has entered into a contract with a third party payor should carefully review the terms and conditions in the contract to determine whether offering and awarding referral gifts or Groupon discounts to patients would impact such third party payor contract.

5. Ethical Implications: ADA Ethics Code

Finally, the provision of referral gifts and Groupon discounts may also raise ethical issues. For example, under Section 4.E. of the ADA Principles of Ethics and Code of Professional Conduct (the "ADA Ethics Code"), a dentist may not "accept or tender 'rebates' or 'split fees.'" For the reasons described above, the referral gifts and Groupon fee arrangement may violate this provision. Moreover, a rebate paid to a patient after a claim for the service has been submitted to an insurer may violate Section 5.B. of the ADA Ethics Code, which provides that "[d]entists shall not represent the fees being charged for providing care in a false or misleading manner". Although compliance with the ADA Ethics Code is not mandatory for all dentists, members of the ADA voluntarily agree to abide by the ADA Ethics Code as a condition of their membership. At the time of writing this memo, it is understood that the ADA Council on Ethics, Bylaws and Judicial Affairs is investigating this issue.

CONCLUSION

There are numerous legal issues for a dentist to consider before offering and awarding referral gifts or Groupon discounts to patients. Hence, a dentist is advised to consult with an attorney familiar with such issues in the state in which the dentist is located prior to proceeding.

Due to Groupon's popularity, it may be that state and federal agencies will soon provide general guidance as to whether the Groupon arrangement violates state and federal laws (indeed, as previously noted, the Oregon Dental Board has recently provided preliminary guidance). If such guidance provides that the Groupon arrangement may under certain circumstances violate state and federal laws, enforcement of such laws may not be far behind.

If general guidance from state agencies is not yet available, the dentist may have the option of seeking an opinion letter from the applicable state dental board as to whether the dentist's marketing plan would run afoul of the state's dental regulations. Doing so, however, would provide no guidance with respect to the federal statute. While a dentist may seek an advisory opinion under the AKS, the process may be costly and time-consuming, and may involve certain risks, particularly if an opinion is sought for past behavior (for which criminal penalties may apply). Legal advice should be sought prior to seeking an advisory opinion either under state law or under the AKS.

Fee Splitting:

Regarding the legality of fee splitting, each state has its own laws which vary one from another.

The Dental Practice Act in Illinois states:

Sec. 23. Refusal, revocation or suspension of dental licenses. The Department may refuse to issue or renew, or may revoke, suspend, place on probation, reprimand or take other disciplinary action as the Department may deem proper, including fines not to exceed $10,000 per violation, with regard to any license for any one or any combination of the following causes: . . .

5. Division of fees or agreeing to split or divide the fees received for dental services with any person for bringing or referring a patient, except in regard to referral services as provided for under Section 45, or assisting in the care or treatment of a patient, without the knowledge of the patient or his legal representative. Nothing in this item 5 affects any bona fide independent contractor or employment arrangements among health care professionals, health facilities, health care providers, or other entities, except as otherwise prohibited by law. Any employment arrangements may include provisions for compensation, health insurance, pension, or other employment benefits for the provision of services within the scope of the licensee's practice under this Act. Nothing in this item 5 shall be construed to require an employment arrangement to receive professional fees for services rendered.

Standards for Professional Conduct In The Practice of Dentistry

Preamble

The Standards for Professional Conduct for licensees of the Virginia Board of Dentistry establishes a set of principles to govern the conduct of licensees in the profession of dentistry. Licensees must respect that the practice of dentistry is a privilege which requires a high position of trust within society. The Board maintains that adherence to these standards will safeguard patients, uphold the laws and regulations governing practice and maintain the public trust. The standards are an expression of types of conduct that are either required or encouraged and that are either prohibited or discouraged to provide further guidance on the requirements for practice set out in the Code of Virginia and the Regulations Governing the Practice of Dentistry and Dental Hygiene.

Scope of Practice

- Keep knowledge and skills current. The privilege, professional status, and a license to practice derive from the knowledge, skill, and experience needed to safely serve the public and patients.
- Seek consultation, if possible whenever the welfare of patients will be safeguarded or advanced by utilizing the knowledge and skills of those who have special skills, knowledge and experience, or advanced training.
- Do not prescribe treatment or use diagnostic techniques or diagnose, cure, or alleviate diseases, infections or other conditions that are not within the scope of the practice of dentistry or that are not based upon accepted scientific knowledge or research.
- Do not treat or prescribe for yourself.

Treating or Prescribing for Family

- Only treat and prescribe based on a bona-fide practitioner-patient relationship, and prescribe by criteria set forth in §54.1-3303 of the Code of Virginia.
- Do not prescribe to a family member a controlled substance or a medicine outside the scope of dentistry.
- When treating a family member or a patient maintain a patient record documenting a bona-fide practitioner-patient relationship.

Staff Supervision

- Protect the health of patients by only assigning to qualified auxiliaries those duties which can be legally delegated.
- Prescribe and supervise the patient care provided by all auxiliary personnel in accordance with the correct type of supervision.
- Maintain documentation that staff has current licenses, certificates for radiology, up-to-date vaccinations, CPR training, HIPPA training, and OSHA training in personnel files.

- Display documents that are required to be posted in the patient receiving area so that all patients might see and read them.
- Be responsible for the professional behavior of staff towards patients and the public at all times.
- Avoid unprofessional behavior with staff
- Provide staff with a safe environment at all times.
- Provide staff with opportunities for continuing education that will keep treatment and services up-to-date and allow staff to meet continuing education requirements
- Supervise staff in dispensing, mixing and following the instruction for materials to be used during treatment.
- Instruct the staff to inform the dentist of any event in the office concerning the welfare of the patient regarding exposures or blood borne pathogens

Practitioner-Patient Communications

- Before performing any dental procedure, accurately inform the patient or the guardian of a minor patient of the diagnoses, prognosis and the benefits, risks, and treatment alternatives to include the consequences of doing nothing.
- Inform the patient of proposed treatment and any reasonable alternatives, in understandable terms to allow the patient to become involved in treatment decisions.
- Acquire informed consent of a patient prior to performing any treatment.
- Refrain from harming the patient and from recommending and performing unnecessary dental services or procedures.
- Specialists must inform the patient that there is a need for continuing care when they complete their specialized care and refer patients to a general dentist or another specialist to continue their care.
- Immediately inform any patient who may have been exposed to blood or other infectious material in the dental office or during a procedure about the need for post exposure evaluation and follow up and to immediately refer the patient to a qualified health care professional
- Do not represent the care being provided in a false or misleading manner
- Inform the patient orally and note in the record any deviation in a procedure due to the dentist's discretion or a situation that arises during treatment that could delay completion of treatment or affect the prognosis for the condition being treated.
- Inform the patient about the materials used for any restoration or procedure such as crowns, bridges, restorative materials, ingestibles, and topicals as to risks, alternatives, benefits, and costs, as well as describing the materials, procedures, or special circumstances in the patient's notes.
- Refrain from removing amalgam restorations from a non-allergic patient for the alleged purpose of removing toxic substances from the body. The same applies to removing any other dental materials.

Patient of Record

- A patient becomes a patient of record when the patient is seated in the dental chair and examination and diagnosis of the oral cavity is initiated.
- In §54.1-2405(B) of the Code of Virginia, "current patient" means a patient who has had a patient encounter with the provider or his professional practice during the two-year period immediately preceding the date of the record transfer.

Patient Records

- Maintain treatment records that are timely, accurate, legible and complete.
- Note all procedures performed as well as substances and materials used.
- Note all drugs with strength and quantity administered and dispensed.
- Safeguard the confidentiality of patient records.
- Upon request of a patient or an authorized dental practitioner, provide any information that will be beneficial for the welfare and future treatment of that patient.
- On request of the patient or the patient's new dentist timely furnish gratuitously or at a reasonable cost, legible copies of all dental and financial records and readable copies of x-rays. This obligation exists whether or not the patient's account is paid in full.
- Comply with §32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.
- Post information concerning the time frame for record retention and destruction in the patient receiving area so that all patients might see and read it.
- Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.
- Maintain records for not less than three years from the last date of treatment as required by the Board of Dentistry and maintain records for longer periods of time to meet contractual obligations or requirements of federal law.
- When closing, selling or relocating a practice, meet the requirements of §54.1-2405 of the Code of Virginia for giving notice and providing records.

Financial Transactions

- Do not accept or tender "rebates" or split fees with other health professionals.
- Maintain a listing of customary fees and represent all fees being charged clearly and accurately.
- Do not use a different fee without providing the patient or third party payers a reasonable explanation which is recorded in the record.
- Return fees to the patient or third party payers in a timely manner if a procedure is not completed or the method of treatment is changed.
- Do not accept a third party payment in full without disclosing to the third party that the patient's payment portion will not be collected.
- Do not increase fees charged to a patient who is covered by a dental benefit plan.

- Do not incorrectly describe a dental procedure in order to receive a greater payment or reimbursement or incorrectly make a non-covered procedure appear to be a covered procedure on a claim form.
- Do not certify in a patient's record or on a third party claim that a procedure is completed when it is not completed.
- Do not use inaccurate dates that are to benefit the patient; false or misleading codes; change the procedure code to justify a false procedure; falsify a claim not having done the procedure, or expand the claim.
- Avoid exploiting the trust a patient has in the professional relationship when promoting or selling a product by: advising the patient or buyer if there is a financial incentive for the dentist to recommend the product; providing the patient with written information about the product's contents and intended use as well as any directions and cautions that apply to its use; and, informing the patient if the product is available elsewhere.
- Do not misrepresent a product's value or necessity or the dentist's professional expertise in recommending products or procedures.

Relationships with Practitioners

- Upon completion of their care, specialists or consulting dentists are to refer back to the referring dentist, or if none, to the dentist of record for future care unless the patient expresses a different preference.
- A dentist who is rendering a second opinion regarding a diagnosis or treatment plan should not have a vested interest in the patient's case and should not seek to secure the patient for treatment unless selected by the patient for care.

Practitioner Responsibility

- Once a course of treatment is undertaken, the dentist shall not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Emergency care must be provided during the notice period to make sure that the patient's oral health is not jeopardized or to stabilize the patient's condition.
- Only prescribe, dispense, and utilize those devices, drugs, dental materials and other agents accepted for dental treatment.
- Make reasonable arrangements for the emergency care of patients of record.
- Exercise reasonable discretion in the selection of patients. Dentists may not refuse patients because of the patient's race, creed, color, sex, or national origin.
- Do not refuse to treat a patient because the individual has AIDS, is HIV positive, or has had hepatitis. Use a proper protocol in the office to protect the public and staff.
- Follow the rules and regulations of HIPPA, OSHA, FDA, and the laws governing health practitioners in the Code of Virginia.
- Be knowledgeable in providing emergency care and have an acceptable emergency plan with delegated duties to the staff in written form, maintain accurate records and be current in basic CPR.

- Avoid interpersonal relationships with patients and staff that could impair professional judgment or risk the possibility of exploiting the veracity and confidence placed in the doctor-patient relationship.

Advertising Ethics

- Do not hold out as exclusive any devise agent, method, or technique if that representation would be false or misleading in any material respect to the public or patients.
- When you advertise, fees must be included stating the cost of all related procedures, services and products which to a substantial likelihood are necessary for the completion of the service as it would be understood by an ordinarily prudent person.
- Disclose the complete name of a specialty board or other organization which conferred certification or another form of credential.
- Do not claim to be a specialist or claim to be superior in any dental specialty or procedure unless you have attained proper credentials from an advanced postgraduate education program accredited by the Commission on Dental Accreditation of the American Dental Association.

Reports and Investigations

- Cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board and timely provide information and records as requested.
- Allow staff to cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board.
- Report the adverse reaction of a drug or dental device to the appropriate medical and dental community and in the case of a serious event to the Food and Drug Administration or Board of Dentistry.
- Provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.
- Become familiar with the special signs of child abuse and report suspected cases to the proper authorities.
- Report to the Board of Dentistry instances of gross or continually faulty treatment by other dentists.

Notice

This guidance document does not address every law and regulation which governs the practice of dentistry. To fully understand your legal responsibilities you should periodically review the laws, regulations, notices and guidance documents provided on the Board of Dentistry webpage, www.dhp.virginia.gov/dentistry.

Law and Regulation on Fee-Splitting

Virginia Board of Medicine

Code of Virginia

§ 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action.

A. The Board may refuse to issue a certificate or license to any applicant; reprimand any person; place any person on probation for such time as it may designate; impose a monetary penalty or terms as it may designate on any person; suspend any license for a stated period of time or indefinitely; or revoke any license for any of the following acts of unprofessional conduct:

9. Violating provisions of this chapter on division of fees or practicing any branch of the healing arts in violation of the provisions of this chapter;

§ 54.1-2962. Division of fees between physicians and surgeons prohibited.

No surgeon or physician shall directly or indirectly share any fee charged for a surgical operation or medical services with a physician who brings, sends or recommends a patient to such surgeon for operation, or such physician for such medical services; and no physician who brings, sends, or recommends any patient to a surgeon for a surgical operation or medical services shall accept from such surgeon or physician any portion of a fee charged for such operation or medical services. This chapter shall not be construed as prohibiting the members of any regularly organized partnership of such surgeons or physicians from making any division of their total fees among themselves as they may determine or a group of duly licensed practitioners of any branch or branches of the healing arts from using their joint fees to defray their joint operating costs. Any person violating the provisions of this section shall be guilty of a Class 1 misdemeanor.

§ 54.1-2962.1. Solicitation or receipt of remuneration in exchange for referral prohibited.

No practitioner of the healing arts shall knowingly and willfully solicit or receive any remuneration directly or indirectly, in cash or in kind, in return for referring an individual or individuals to a facility or institution as defined in § 37.2-100 or a hospital as defined in § 32.1-123. The Board shall adopt regulations as necessary to carry out the provisions of this section. Such regulations shall exclude from the definition of "remuneration" any payments, business arrangements, or payment practices not prohibited by Title 42, Section 1320a-7b (b) of the United States Code, as amended, or any regulations promulgated pursuant thereto.

§ 54.1-2964. Disclosure of interest in referral facilities and clinical laboratories.

A. Any practitioner of the healing arts shall, prior to referral of a patient to any facility or entity engaged in the provision of health-related services, appliances or devices, including but not limited to physical therapy, hearing testing, or sale or fitting of hearing aids or eyeglasses provide the patient with a notice in bold print that discloses any known material financial interest of or ownership by the practitioner in such facility or entity and states that the services,

appliances or devices may be available from other suppliers in the community. In making any such referral, the practitioner of the healing arts may render such recommendations as he considers appropriate, but shall advise the patient of his freedom of choice in the selection of such facility or entity. This section shall not be construed to permit any of the practices prohibited in § 54.1-2914 or Chapter 24.1 (§ 54.1-2410 et seq.) of this title.

In addition, any practitioner of the healing arts shall, prior to ordering any medical test from an independent clinical laboratory for a patient, provide the patient with notice in bold print that discloses any known material financial interest or ownership by the practitioner in such laboratory unless the independent clinical laboratory is operated by a publicly held corporation. The practitioner shall inform the patient about the accreditation status and credentials of the laboratory.

B. The Attorney General, an attorney of the Commonwealth, the attorney for a city, county or town, or any aggrieved patient may cause an action to be brought in the appropriate circuit court in the name of the Commonwealth, of the county, city or town, or of any aggrieved patient, to enjoin any violation of this section. The circuit court having jurisdiction may enjoin such violations, notwithstanding the existence of an adequate remedy at law. When an injunction is issued, the circuit court may impose a civil fine to be paid to the Literary Fund not to exceed $1,000. In any action under this section, it shall not be necessary that damages be proven.

Regulations

18VAC85-20-80. Solicitation or remuneration in exchange for referral.

A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in §37.2-100 of the Code of Virginia, or hospital as defined in §32.1-123 of the Code of Virginia. Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, §1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.

DRAFT Legislative Proposal

Prohibition on Fee-Splitting

Recommendation of the Regulatory/Legislative Committee:

No dentist shall directly or indirectly accept or tender a rebate, compensation or inducement, whether in the form of money or otherwise, or split a fee with any third party, including another dentist, for bringing, sending or recommending a patient for dental services. Advertising or marketing dental services by sharing a specified portion of the professional fees collected from prospective or actual patients with the entity providing the advertising or marketing shall constitute fee splitting.

"Word-smithed" version of Committee Recommendation:

No dentist shall directly or indirectly accept or tender any form of compensation or inducement or split a fee with any third party, including another dentist, for bringing, sending or recommending a patient for dental services. Advertising or marketing dental services by sharing a specified portion of the professional fees collected from prospective or actual patients with the entity providing the advertising or marketing shall constitute fee splitting.

Agenda Item: **Recommendation on Adoption of Guidance Document**

The Regulatory/Legislative Committee recommended adoption of the draft guidance document on **Implementation of Periodic Office Inspections for Sedation/Anesthesia Permit Holders** as it was presented to the Committee. Subsequent to the Committee's action, Ms. Reen has revised the document in response to questions raised by licensees and recommendations made by staff in the Enforcement Division. The subsequent revisions made by Ms. Reen are highlighted to facilitate review and discussion.

Possible Actions following review and discussion:

- Request further development of the document by staff and/or the Regulatory/Legislative Committee
- Adopt with or without amendments

Guidance Document Discussion Draft

Virginia Board of Dentistry

Periodic Office Inspections for Administration of Sedation and Anesthesia

Purpose

The purpose of instituting periodic office inspections is to foster and verify compliance with regulatory requirements by dentists who hold a permit to administer sedation or general anesthesia (permit holders). Verifying compliance with the requirements will assure that appropriate protections are in place for the health and safety of patients who undergo conscious/moderate sedation, deep sedation, or general anesthesia for dental treatment.

Excerpts of Applicable Laws and Regulation

- Employees of the Department of Health Professions, when properly identified, shall be authorized, during ordinary business hours, to enter and inspect any dental office or dental laboratory for the purpose of enforcing the provisions of this chapter as provided by §54.1-2703 of the Code of Virginia.
- The Board shall establish by regulation reasonable education, training, and equipment standards for safe administration and monitoring of sedation and anesthesia to patients in a dental office as provided by §54.1-2709.5 of the Code.
- Part IV of the Regulations Governing Dental Practice addresses the requirements for administration of anesthesia, sedation and analgesia beginning at 18VAC60-20-107.

Scope of Periodic Inspections

- Dentists who do not provide any level of sedation and those that only provide minimal sedation do not require a permit and are not subject to periodic inspections.
- Oral and maxillofacial surgeons (OMSs) who maintain membership in AAOMS and who provide the Board with the reports which result from the periodic office examinations required by AAOMS do not require a permit and are not subject to periodic inspections by the Board so long as each Virginia office an OMS practices in has undergone an AAMOS periodic office examination within five years and the reports of the examinations are provided to the Board upon request.
- Every OMS who does not maintain AAOMS membership or who do not cannot or will not provide an AAOMS report to the Board is required to hold a permit to administer sedation or general anesthesia and are subject to periodic inspections by the Board.
- Every dentist who holds a permit to administer conscious/moderate sedation, enteral conscious/moderate sedation, or deep sedation and general anesthesia is subject to periodic unannounced office inspections.
- Permit holders who practice in multiple offices shall identify each location for inspection. Each office will be inspected at least once in an inspection cycle. If a permit holder is the sole practitioner in each of the locations, inspections of each office will be coordinated to address findings in a comprehensive report.
- Practices with multiple permit holders will be inspected for general compliance at least once in an inspection cycle. These inspections will address the compliance of each

DRAFT

holder [redacted]

- [redacted]

Inspection Cycle

The standard inspection cycle is to inspect each permit holder's practice(s) once every three years. This cycle will be followed when an inspection finds that all requirements have been met or that only a few minor violations have been identified for correction which might be resolved through a confidential consent agreement. Significant findings of violations may result in administrative proceedings, disciplinary action and more frequent inspections.

Initiation of Inspections

The Board will conduct a pre-inspection survey of all permit holders. The purpose of this survey will be to collect information about the level of sedation practiced, practice locations and staffing. This information will facilitate planning for inspections. Permit holders will receive a copy of this guidance document and the inspection form with the survey.

Following review of the survey results, the Enforcement Division of the Department of Health Professions will initiate [redacted] inspections of the offices of permit holders.

Following initiation of the periodic inspections, the Board will send an e-mail request to each OMS for submission of the most recent reports which resulted from the periodic office examinations required by AAOMS. This request will include a form to be completed and returned to the Board with the name of the primary contact person and the name, address, and phone number of each office where the OMS practices.

Costs Related to Inspections

Permit holders will not be charged an inspection fee for a periodic inspection. A $350 fee will be charged for any additional inspections that result from a disciplinary order issued to address findings of non-compliance in periodic inspections.

Inspection Reports and AOMS Office Examination Results

Inspection reports and AAOMS results will be submitted to the Board for review. The Board will review the information received to determine if the permit holder or AAOMS member is in compliance with the regulatory requirements addressed in the inspection form. The inspection reports and AAOMS results are confidential documents pursuant to §54.1-2400.2 of the Code of Virginia.

*See 18VAC60-20-110(E) and 18VAC60-20-120(H)

Agenda Item: Purpose and Development of Guidance Documents

Given the current interests of board members in developing guidance documents on a variety of subjects, Ms. Reen thought a discussion of their purpose would be helpful to facilitate a board member's interest in proposing a guidance documents. It should also assist the Board as a body in deciding when a guidance document is warranted.

A guidance document is defined in §2.2-4001 of the Code of Virginia as "...any document developed by a state agency or staff that provides information or guidance of general applicability to the staff or public to interpret or implement statutes or the agency's rules or regulations..." Guidance documents can only provide insight into an existing law or regulation. They cannot expand or limit any law or regulation and cannot establish requirements that are not in law or regulation.

Ms. Reen is recommending that:

- the decision to develop a guidance document should be by action of the Board.
- a member wishing to propose a guidance document should submit a written request for inclusion in the agenda package for the next board business meeting. The request should identify the statute or regulation of concern and explain the need for its interpretation or guidance.
- if the Board decides to develop a guidance document, the matter should be assigned to the Regulatory/Legislative Committee for development. Upon assignment to the Committee, the Committee will direct staff on the priority to be given to this matter in relation to the other matters pending action by the Committee.
- Staff is authorized to undertake the necessary research and to develop a draft for discussion consistent with the priority assigned by the Committee.

Agenda Item: Discussion Draft Guideline for Conscious/Moderate Sedation

Dr. Levin developed this guidance document to address implementation of the regulations on sedation. He presented it at the March Board meeting for discussion. Ms. Tysinger requested that discussion be deferred to the June meeting so a legal review by board counsel might be completed.

Mr. Rutkowski completed his review and contacted Ms. Reen to discuss his concerns about inconsistencies with the current sedation and anesthesia regulations and about guidance which exceeds the scope of the regulations. He also noted that Guidance Document 60-13 needs to be updated to reflect the recent changes in regulations.

Discussion Draft

Guideline for Conscious/Moderate Sedation

These guidelines are intended to provide some additional understanding of the regulations on sedation but it is incumbent for the dentist to recognize that every situation does not fit into a single mold and may be different in every patient.

The use of large doses of local anesthetic with sedation may increase the level of central nervous system depression. The use of minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and pharmacologic implications of combining local anesthetic agents and sedative agents.

The proper equipment as listed in the regulations must always be working properly and available when providing sedation, this is the responsibility of the treating dentist. Emergency drugs must be available and not expired. Protocols for the management of emergencies must be developed and written down as well as training programs held at frequent intervals. These training programs should be updated particularly with change of staff. Outdated drugs should be disposed of properly and replaced on a definite schedule; this is also responsibility of the treating dentist.

It is the responsibility of the treating dentist to provide and maintain all required equipment in good working order.

All drugs and /or techniques used for sedation should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Patients whose only response is reflex withdrawal from repeated painful stimuli would not be sedated properly.

Oral and written Consents must be obtained for **ALL** levels of sedation including minimal sedation with explanation of risks, benefits, alternatives and written post op instructions and be part of dental records.

Proper documentation of time, amount, and route all drugs were administered and keep in patient record. All vital signs must be recorded at proper time intervals and becomes part of patient record.

The following definition applies:

Maximum recommended dose (MRD) - maximum FDA- Recommended dose of a drug as printed in FDA- approved labeling for unmonitored home use.

Because sedation and general anesthetic are a continuum it is not always possible to predict how an individual patient will respond. The dentist intending to produce a given level of sedation must be able to diagnose and manage the physiological consequences and able to reverse and rescue patients whose level of sedation becomes deeper than initially intended.

For any level of sedation the dentist must have and provide the appropriate training skills, drugs, and equipment to identify and manage such an occurrence until emergency medical service arrives or the patient returns to the intended level of sedation without airway or cardiovascular complications. All events should be well documented.

When the intent is minimal sedation and the appropriate dosage of drugs is administered then the definition of enteral and /or the combination does not apply to minimal sedation.

When the intent is minimal sedation for adults the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug can be prescribed for **unmonitored home use.**

The use of preoperative sedative drugs for children (≤ 12 years) prior to arrival in the dental office must be avoided due to the risk of injury and unobserves respiratory obstruction dressing transport by untrained individuals.

Children (< 12 years) can become moderately sedated despite the intended level of minimal sedation should this occur, the guidelines for moderate sedation apply.

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation if level of sedation at minimal level is maintained. Nitrous oxide/oxygen when used in combination with sedative drugs may produce minimal, moderate, deep sedation or general anesthesia.

An updated health history, signed consent form, monitoring records are to be repeated, each time sedation is performed. ASA physical status is recorded, pre-sedation and written post sedation vital signs recorded, post operative instructions included in records. Monitoring records to include drug-amount-time administered. Vital signs are recorded pre, during (5 minutes), and post treatment interval.

The dentist providing the sedation must be familiar with the current ADA guidelines, VA BOD guidelines and Laws & Regulations of the VA BOD. Post permit, and be current ACLS and BOD course required. PALS

Only ASA Class I & II may be sedated in the dental office.

Report any adverse reaction to the VA BOD that required hospitalization within 30 days of event that results from a patient receiving any form of local or sedative agent that is admitted to a hospital within 24 hrs following the event.

Any patient requiring sedation must be given proper instruction (written is the best form) regarding not driving, intake of liquids or food, arriving accompanied by an adult who is the driver to & from the dental office. Treating dentist must furnish his telephone number in order to be contacted by patient or parent if necessary.

Agenda Item: Proposed Guidance Document on Endodontic Root Canal Treatment Record Keeping Requirements

Dr. Gaskins developed this guidance document to address the inadequate record keeping for root canal treatment he is seeing in numerous disciplinary cases. He presented it at the May 2, 2014 Regulatory/Legislative Committee meeting for discussion. He noted that his draft was reviewed by seven board certified endodontists who confirmed these standards for endodontic treatment. By consensus, the Committee agreed to forward the draft to the Board for consideration on June 13, 2014.

Subsequent to the Committee meeting, Ms. Reen contacted the American Association of Endodontists and obtained the recordkeeping information available in the Guide to Clinical Endodontics and an assessment form for review by the Board.

Ms. Reen requests that the Board address the following considerations before acting on the guidance document:

- Enforceable requirements can only be established by law or regulation,
- Currently there are no legal provisions addressing recordkeeping for specialty practices; and,
- The implications of:
    - Deviating from the historical practice of relying on the national standards set by the dental specialty certifying boards in reviewing disciplinary cases,
    - only addressing records for root canal treatment in regards to endodontics, and
    - only addressing endodontics in regard to other specialty practice areas.

Virginia Board of Dentistry
Guidance Document

Endodontic Root Canal Treatment Record Keeping Requirements

Pursuant (but not limited) to both **§ 54.1-2706** - *The Board may suspend for a stated period or indefinitely, or revoke any license or censure or reprimand any licensee or place him on probation for such time as it may designate for any of the following causes:*

4. Any unprofessional conduct likely to defraud or to deceive the public or patients;
5. Intentional or negligent conduct in the practice of dentistry which causes or is likely to cause injury to a patient or patients;
11. Practicing or causing others to practice in a manner as to be a danger to the health and welfare of his patients or to the public;
12. Practicing outside the scope of the dentist's education, training, and experience;

and to **18 VAC 60-20-170. Acts constituting unprofessional conduct.**

*The following practices shall constitute unprofessional conduct within the meaning of **§ 54.1-2706** of the Code of Virginia:*

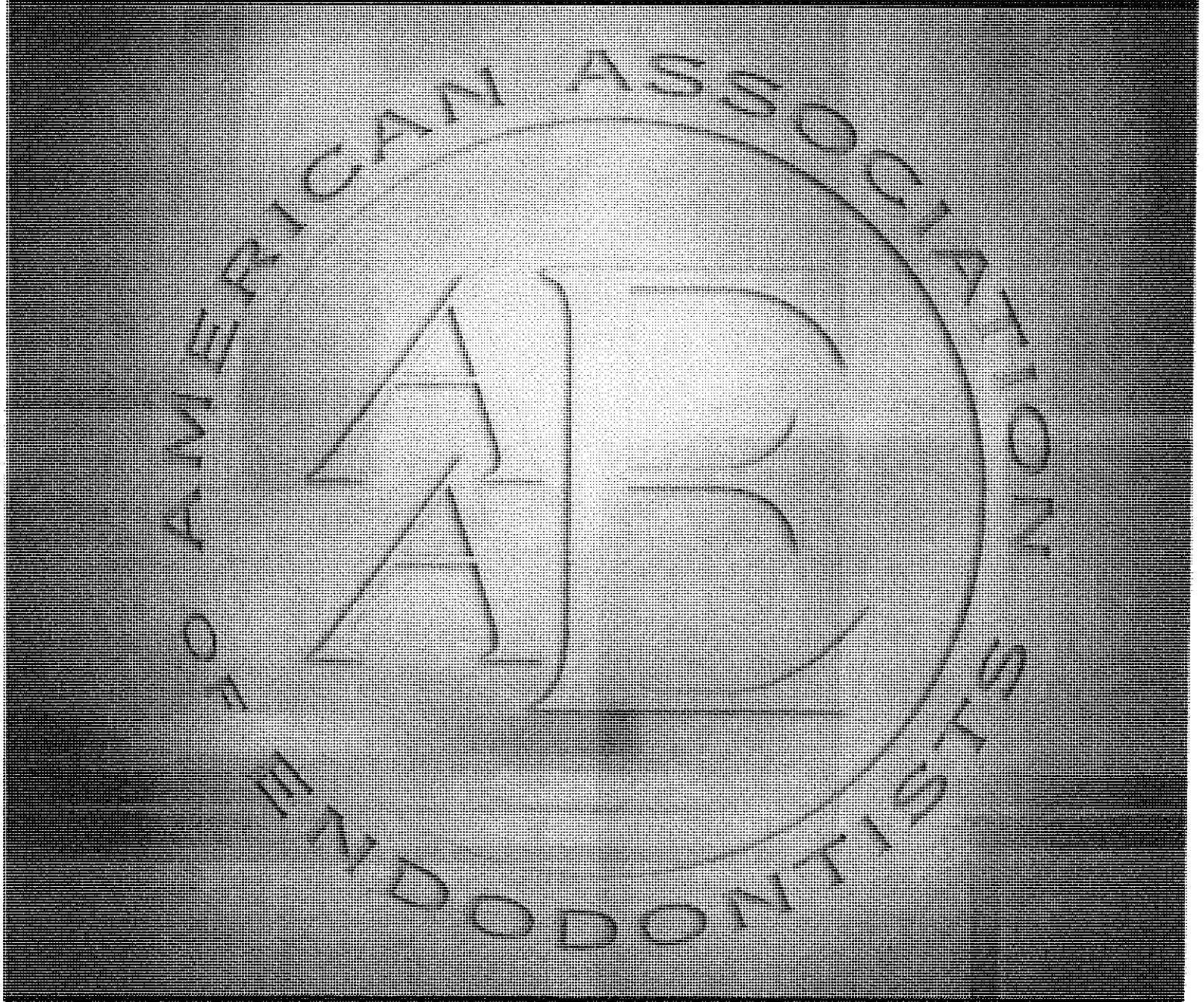
3. Misrepresenting to a patient and the public the materials or methods and techniques the licensee uses or intends to use .

Whereas, endodontic (root canal) treatment oftentimes can initiate patient satisfaction complaints, and accounts for a significant number of legal proceedings, The Board of Dentistry provides the following outline to assist licensees with the current elements required to be maintained in a patient's endodontic treatment record:

- Chief Complaint; History of Complaint
- Clinical Findings + Recent PA Radiograph
- Diagnosis, Tooth Number

- Informed Consent Documentation
- Local Anesthesia (Concentration, Vasoconstrictor, Amt. Dispensed)
- Sedation Documentation (If Applicable)
- Rubber Dam Usage Notation
- Working Length(s) / Per Canal + PA Radiograph
- Instrumentation (Sizes Achieved) + PA Radiograph
- Irrigation Notes (Solution(s), Concentrations)
- Medicament(s) (If used between more than one appointment)
- Type/Method of Obturation; Material(s) Placed + PA Radiograph
- Spacer (ex.: Cotton, Resin); Temporary Restoration
- Prescriptions, Patient Instructions
- Other Notes, Comments

Guide to Clinical Endodontics



Fifth Edition

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American Association of Endodontists

PIIS

A. Endodontic Examination and Diagnosis

Many features of evaluation in endodontics are common to all dental practice. Diagnostic evaluation of pulpal and periradicular status must be performed for every tooth to be treated. Inclusion of control or reference teeth in examination is essential. Differential diagnosis should be considered when indicated.

An adequate medical and dental history, the patient's description of the chief complaint(s) and visual and radiographic examination provide basic information. Some indicated tests, such as thermal, electrical, cavity, anesthesia, percussion, palpation and mobility, should be accomplished. Additional periodontal examination/evaluation, transillumination and observation of occlusal discrepancies may be indicated.

Reproducing the patient's symptoms is desirable if not mandatory. In some situations, it may be advisable to take radiographic images from more than one angle. It may also be necessary to make/take panoramic radiographs, bitewing radiographs, occlusal plane films and radiographs of the contralateral and opposing teeth. The use of enhanced magnification, illumination or intraoral photography are common adjuncts. The use of small volume cone beam-computed tomography is sometimes indicated. For guidance on the use of CBCT, see the joint *AAE/AAOMR Position Statement on the Use of CBCT in Endodontics*, found at www.aae.org/guidelines.

The diagnostic categories used should be those specified in the AAE's *Glossary of Endodontic Terms* for both pulpal and periradicular diagnoses. It may be necessary to recommend follow-up visits for some patients at periodic intervals to compare specific data from the various examinations to facilitate an accurate pulpal and periradicular diagnosis. Waiting for symptoms to exacerbate might be indicated in some situations before treatment is initiated. At times, it may be necessary to attempt to secure radiographic images from previous practitioners to assist with the evaluation process.

Objectives:

a. To determine diagnosis and the need for any treatment.
b. To determine those cases deemed to be too complex for the level of training, experience and expertise of the practitioner. (See the *AAE Endodontic Case Difficulty Assessment Form and Guidelines*.)
c. To determine if it is advisable to consult with, or refer to, other health professionals.

SELECTED REFERENCES:

JOE Topic Collections: Diagnosis www.jendodon.com/content/diagnosis

Bhaskar SN. Periapical lesions – types, incidence and clinical features. Oral Surg Oral Med Oral Path 1966;21:657.

Bender IB. Factors influencing radiographic appearance of bony lesions. J Endod 1982;8:161.

Bender IB, Landau MA, Fonseca S, Trowbridge, HO. The optimum placement site of the electrode in electric pulp testing of the twelve anterior teeth. J Am Dent Assoc 1989;118(3):305.

Brannstrom M. The hydrodymanic theory of dentinal pain: Sensation in preparations, caries and dentinal crack syndrome. J Endod 1986;12:453.

Byers MR. Effects of inflammation on dental sensory nerves and vice versa. Proc Finn Dent Soc 1992;88:499.

Cameron CE. Cracked tooth syndrome. J Am Dent Assoc 1964;68:405.

Drinnan AL. Differential diagnosis of orofacial pain. Dent Clin North Am 1987;31:627.

Fuss Z, Trowbridge HO, Bender IB, Rickoff B, Sorin S. Assessment of reliability of electrical and thermal pulp testing agents. J Endod 1986;12:301.

B. Endodontic Treatment Planning, Records and Follow-up Visits

Endodontic treatment is based on an analysis of all diagnostic information. Treatment planning should include a determination of the strategic importance of the tooth or teeth considered for treatment, the prognosis and the urgency of treatment. It is incumbent upon all providers of endodontic care to address endodontically-related emergencies in a timely manner. Other factors, such as excessively curved canals, periodontal disease, occlusion, tooth fractures, calcified or occluded canals, restorability and teeth with complex root canal morphology, should be considered. (See the *AAE Endodontic Case Difficulty Assessment Form and Guidelines*.)

Treatment records should include the chief complaint(s) in the patient's own words; a current medical and dental history; the results of diagnostic tests and clinical examination; clinical impressions based on subjective and objective evaluations; the pulpal and periradicular diagnoses and treatment recommendations; a description of treatment rendered, including pulpal status upon entry; the prognosis as reported to the patient; recommendations for tooth restoration; and the preoperative, appropriate working, postoperative and follow-up radiographic examination. Informed consent is required. It may be helpful to record patient commentaries before, during and after treatment. Prescriptions must be recorded, and consultations should be made part of the patient record.

Endodontic care includes evaluation of the patient's postoperative response to the clinical procedures. Providers of endodontic services should encourage patients to return at appropriate follow-up intervals for evaluation.

SELECTED REFERENCES:

Allen RK, Newton CW, Brown CE. A statistical analysis of surgical and non-surgical endodontic retreatment cases. J Endod 1989;15:261.

Bystrom A, Happonen RP, Sjogren U, Sundqvist G. Healing of periapical lesions of pulpless teeth after endodontic treatment with controlled asepsis. Endod Dent Tramatol 1987;3:58.

Cohen S, Schwartz S. Endodontic complications and the law. J Endod 1987;13:191.

Crump MC. Differential diagnosis in endodontic failure. Dent Clin North Am 1979;23:617.

De Vore DT. Legal considerations for treatment following trauma to teeth. Dent Clin North Am 1995;39:203.

Health Insurance Portability and Accountability Act of 1996.

Lin LM, Skribner JE, Gaengler P. Factors associated with endodontic treatment failures. J Endod 1992;18:625.

Ray HA, Trope M. Periapical status of endodontically treated teeth in relation to the technical quality of the root filling and the coronal restoration. Int Endod J 1995;28:12.

Rud J, Andreasen JO. A study of failures after endodontic surgery by radiographic, histologic and stereomicroscopic methods. Int J Oral Surg 1972;1:311.

Seltzer S, Bender IB, Smith J, Freedman I, Nazimov H. Endodontic failures – an analysis based on clinical, roentgenographic, and histologic findings, Part II. Oral Surg Oral Med Oral Path 1967;23:517.

Sjogren U, Hagglund B, Sundqvist G, Wing K. Factors affecting the long-term results of endodontic treatment. J Endod 1990;16:498.

Himel VT. Diagnostic procedures for evaluating pulpally involved teeth. Curr Opin Dent 1992;2:72.

Hutter JW. Facial space infections of odontogenic origin. J Endod 1991;17:422.

Josell SD. Evaluation, diagnosis, and treatment of the traumatized patient. Dent Clin North Am 1995;39:15.

Lalonde ER, Luebke RG. The frequency and distribution of periapical cysts and granulomas. An evaluation of 800 specimens. Oral Surg Oral Med Oral Path 1968;25:861.

Pantera E, Anderson R, Pantera C. Reliability of electric pulp testing after pulpal testing with dichlorodifluoromethane. J Endod 1993;19:312.

Seltzer S, Bender IB. Cognitive dissonance in endodontics. Oral Surg Oral Med Oral Path 1965;20:505.

Seltzer S, Bender IB, Ziontz M. The dynamics of pulp inflammation: Correlations between diagnostic data and actual histologic findings in the pulp. Oral Surg Oral Med Oral Path 1963;16:846,16:969.

Simon JH. Incidence of periapical cysts in relation to the root canal. J Endod 1980;6:845.

Trowbridge HO, Franks M, Korostoff E, Emling R. Sensory response to thermal stimulation in human teeth. J Endod 1980;6:167.

AAE Endodontic Case Difficulty Assessment Form and Guidelines

PATIENT INFORMATION

Name_____

Address_____

City/State/Zip_____

Phone_____

DISPOSITION

Treat in Office: Yes ☐ No ☐

Refer Patient to:

_____

Date:_____

Guidelines for Using the AAE Endodontic Case Difficulty Assessment Form

The AAE designed the Endodontic Case Difficulty Assessment Form for use in endodontic curricula. The Assessment Form makes case selection more efficient, more consistent and easier to document. Dentists may also choose to use the Assessment Form to help with referral decision making and record keeping.

Conditions listed in this form should be considered potential risk factors that may complicate treatment and adversely affect the outcome. Levels of difficulty are sets of conditions that may not be controllable by the dentist. Risk factors can influence the ability to provide care at a consistently predictable level and impact the appropriate provision of care and quality assurance.

The Assessment Form enables a practitioner to assign a level of difficulty to a particular case.

LEVELS OF DIFFICULTY

MINIMAL DIFFICULTY	Preoperative condition indicates routine complexity (uncomplicated). These types of cases would exhibit only those factors listed in the MINIMAL DIFFICULTY category. Achieving a predictable treatment outcome should be attainable by a competent practitioner with limited experience.
MODERATE DIFFICULTY	Preoperative condition is complicated, exhibiting one or more patient or treatment factors listed in the MODERATE DIFFICULTY category. Achieving a predictable treatment outcome will be challenging for a competent, experienced practitioner.
HIGH DIFFICULTY	Preoperative condition is exceptionally complicated, exhibiting several factors listed in the MODERATE DIFFICULTY category or at least one in the HIGH DIFFICULTY category. Achieving a predictable treatment outcome will be challenging for even the most experienced practitioner with an extensive history of favorable outcomes.

Review your assessment of each case to determine the level of difficulty. If the level of difficulty exceeds your experience and comfort, you might consider referral to an endodontist.

The contribution of the Canadian Academy of Endodontics and others to the development of this form is gratefully acknowledged.

The AAE Endodontic Case Difficulty Assessment Form is designed to aid the practitioner in determining appropriate case disposition. The American Association of Endodontists neither expressly nor implicitly warrants any positive results associated with the use of this form. This form may be reproduced but may not be amended or altered in any way.

© American Association of Endodontists, 211 E. Chicago Ave., Suite 1100, Chicago, IL 60611-2691; Phone: 800/872-3636 or 312/266-7255; Fax: 866/451-9020 or 312/266-9867; E-mail: info@aae.org; Web site: *www.aae.org*

AAE Endodontic Case Difficulty Assessment Form

Criteria and Subcriteria	Minimal Difficulty	Moderate Difficulty	High Difficulty
A. PATIENT CONSIDERATIONS			
Medical history	☐ No medical problem (ASA Class 1*)	☐ One or more medical problems (ASA Class 2*)	☐ Complex medical history/serious illness/disability (ASA Classes 3-5*)
Anesthesia	☐ No history of anesthesia problems	☐ Vasoconstrictor intolerance	☐ Difficulty achieving anesthesia
Patient disposition	☐ Cooperative and compliant	☐ Anxious but cooperative	☐ Uncooperative
Ability to open mouth	☐ No limitation	☐ Slight limitation in opening	☐ Significant limitation in opening
Gag reflex	☐ None	☐ Gags occasionally with radiographs/treatment	☐ Extreme gag reflex which has compromised past dental care
Emergency condition	☐ Minimum pain or swelling	☐ Moderate pain or swelling	☐ Severe pain or swelling
B. DIAGNOSTIC AND TREATMENT CONSIDERATIONS			
Diagnosis	☐ Signs and symptoms consistent with recognized pulpal and periapical conditions	☐ Extensive differential diagnosis of usual signs and symptoms required	☐ Confusing and complex signs and symptoms: difficult diagnosis ☐ History of chronic oral/facial pain
Radiographic difficulties	☐ Minimal difficulty obtaining/interpreting radiographs	☐ Moderate difficulty obtaining/interpreting radiographs (*e.g.*, high floor of mouth, narrow or low palatal vault, presence of tori)	☐ Extreme difficulty obtaining/interpreting radiographs (*e.g.*, superimposed anatomical structures)
Position in the arch	☐ Anterior/premolar ☐ Slight inclination (<10°) ☐ Slight rotation (<10°)	☐ 1st molar ☐ Moderate inclination (10-30°) ☐ Moderate rotation (10-30°)	☐ 2nd or 3rd molar ☐ Extreme inclination (>30°) ☐ Extreme rotation (>30°)
Tooth isolation	☐ Routine rubber dam placement	☐ Simple pretreatment modification required for rubber dam isolation	☐ Extensive pretreatment modification required for rubber dam isolation
Crown morphology	☐ Normal original crown morphology	☐ Full coverage restoration ☐ Porcelain restoration ☐ Bridge abutment ☐ Moderate deviation from normal tooth/root form (*e.g.*, taurodontism, microdens) ☐ Teeth with extensive coronal destruction	☐ Restoration does not reflect original anatomy/alignment ☐ Significant deviation from normal tooth/root form (*e.g.*, fusion, dens in dente)
Canal and root morphology	☐ Slight or no curvature (<10°) ☐ Closed apex (<1 mm in diameter)	☐ Moderate curvature (10-30°) ☐ Crown axis differs moderately from root axis. Apical opening 1-1.5 mm in diameter	☐ Extreme curvature (>30°) or S-shaped curve ☐ Mandibular premolar or anterior with 2 roots ☐ Maxillary premolar with 3 roots ☐ Canal divides in the middle or apical third ☐ Very long tooth (>25 mm) ☐ Open apex (>1.5 mm in diameter)
Radiographic appearance of canal(s)	☐ Canal(s) visible and not reduced in size	☐ Canal(s) and chamber visible but reduced in size ☐ Pulp stones	☐ Indistinct canal path ☐ Canal(s) not visible
Resorption	☐ No resorption evident	☐ Minimal apical resorption	☐ Extensive apical resorption ☐ Internal resorption ☐ External resorption
C. ADDITIONAL CONSIDERATIONS			
Trauma history	☐ Uncomplicated crown fracture of mature or immature teeth	☐ Complicated crown fracture of mature teeth ☐ Subluxation	☐ Complicated crown fracture of immature teeth ☐ Horizontal root fracture ☐ Alveolar fracture ☐ Intrusive, extrusive or lateral luxation ☐ Avulsion
Endodontic treatment history	☐ No previous treatment	☐ Previous access without complications	☐ Previous access with complications (*e.g.*, perforation, non-negotiated canal, ledge, separated instrument) ☐ Previous surgical or nonsurgical endodontic treatment completed
Periodontal-endodontic condition	☐ None or mild periodontal disease	☐ Concurrent moderate periodontal disease	☐ Concurrent severe periodontal disease ☐ Cracked teeth with periodontal complications ☐ Combined endodontic/periodontic lesion ☐ Root amputation prior to endodontic treatment

*American Society of Anesthesiologists (ASA) Classification System

Class 1: No systemic illness. Patient healthy.
Class 2: Patient with mild degree of systemic illness, but without functional restrictions, *e.g.*, well-controlled hypertension.
Class 3: Patient with severe degree of systemic illness which limits activities, but does not immobilize the patient.
Class 4: Patient with severe systemic illness that immobilizes and is sometimes life threatening.
Class 5: Patient will not survive more than 24 hours whether or not surgical intervention takes place.

www.asahq.org/clinical/physicalstatus.htm

Agenda Item: Billing for Periodic Exams Performed by Dental Hygienists

Dr. Watkins is requesting discussion of the Board's position on the practice of billing for periodic exams performed by dental hygienists and consideration of developing a guidance document on the subject.

Information included in the agenda package:

- E-mails between Dr. Watkins and Ms. Reen
- Regulations Governing Dental Practice sections 18VAC60-20-190 and 18VAC60-20-220
- September 30, 2002 Special Bulletin, Clarification of General Supervision

The 2014 CDT Code will be available for projection at the meeting.

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, April 02, 2014 5:06 PM
To: DDSJDW@aol.com
Cc: Palmatier, Kelley (DHP)
Subject: RE: Question

Importance: Low

Hi Jim:
Yes, this can be on the June Board meeting agenda for you to discuss. It would be helpful if you would provide any proposed language and identify any documents/reference material you would like included in the agenda package to facilitate the discussion **by May 22nd**.

Information that may be helpful to you is that:

- the list of non-delegable duties in 18VAC60-20-190 of our regs does not include "examination" or "evaluation" but it does list final diagnosis and treatment planning.
- 18VAC60-20-220 of our regs permits dental hygienists to perform an initial exam under indirect supervision and to perform a clinical exam under indirect or general supervision.
- CDT 2014 says in its introduction to Clinical Oral Evaluations: "The collection and recording of some data and components of the dental examination may be delegated: however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist.
- CDT 2014 lists D0120 as follows: "periodic oral evaluation- established patient An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated ..."

Also, this e-mail I sent to you in August gives the Board's history on this subject:

Date: 8/29/2013 6:00:45 PM

Attachments:
SDentistryC13082916090.pdf

Hi Jim:
Since Debbie will be out of the office until next Thursday, I discussed this with Kelley today and decided to respond directly to you. No guidance document or regulation addresses billing for an exam done by a dental hygienist under general supervision. The attached Special Bulletin on General Supervision was issued by the Board shortly after implementing the Emergency Regulations on General Supervision. There are three Q&As on the topic of billing for exams – on the second page (numbered 4) see the 3rd Q&A and on the 3rd page (numbered 5) see the 2nd and 6th Q&As. In the pending case, I checked the order for treatment under general supervision which did include "PeriodicX" in the services to be provided. I also looked at the CDT Code (2011-2012) introductory information on clinical oral evaluations as well as Code DO120. The Board has never discussed use of this Code and actually declined to do so as indicated in the Special Bulletin.
Please let me know if you have any further questions about billing before you might respond to Debbie's questions in her August 22, 2013 e-mail.
Smile,
Sandy

Smile,
Sandy

From: DDSJDW@aol.com [mailto:DDSJDW@aol.com]
Sent: Tuesday, April 01, 2014 6:46 PM
To: Reen, Sandra (DHP)
Subject: Question

Hi, Sandy.

I mentioned to Kelly on Friday that I was anxious to hear the IFC on our 11am case that day; only to find out that the Respondent signed the Consent Agreement the day before. It was the first case where there was a complaint about a dentist billing for a Periodic Exam when the exam was done by his hygienist while on General Supervision. I had reviewed the case and written it up as a violation as it was my understanding that hygienists could NOT bill for an exam under GS (because hygienists cannot diagnose). Debbie did not agree as she felt it was done in offices; and now, I have had hygienists that have worked with me part-time tell me that other offices routinely bill out a "periodic exam" by the DH when working under GS. I feel like there needs to be some type of clarification on this issue (possibly a Guidance Document); so Kelly recommended that I ask you if the issue can be placed on the agenda for our next meeting. Is that possible? Is this a valid concern? Have I overlooked something in my understanding of the guidelines?

Jim

Part VI. Direction and Delegation of Duties.

18VAC60-20-190. Nondelegable duties; dentists.

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;
2. Performing surgical or cutting procedures on hard or soft tissue;
3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist, who meets the requirements of 18VAC60-20-81, may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;
4. Authorization of work orders for any appliance or prosthetic device or restoration to be inserted into a patient's mouth;
5. Operation of high speed rotary instruments in the mouth;
6. Administering and monitoring general anesthetics and conscious sedation except as provided for in § 54.1-2701 of the Code of Virginia and 18VAC60-20-108 C, 18VAC60-20-110 F, and 18VAC60-20-120 F;
7. Condensing, contouring or adjusting any final, fixed or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental assistants II with advanced training as specified in 18VAC60-20-61 B;
8. Final positioning and attachment of orthodontic bonds and bands; and
9. Final adjustment and fitting of crowns and bridges in preparation for final cementation.

18VAC60-20-220. Dental hygienists.

A. The following duties shall only be delegated to dental hygienists under direction and may be performed under indirect supervision:

1. Scaling and/or root planing of natural and restored teeth using hand instruments, rotary instruments and ultrasonic devices under anesthesia.
2. Performing an initial examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets or other abnormal conditions for assisting the dentist in the diagnosis.
3. Administering nitrous oxide or local anesthesia by dental hygienists qualified in accordance with the requirements of 18VAC60-20-81.

B. The following duties shall only be delegated to dental hygienists and may be delegated by written order in accordance with § 54.1-2722 of the Code of Virginia to be performed under general supervision when the dentist may not be present:

1. Scaling and/or root planing of natural and restored teeth using hand instruments, rotary instruments and ultrasonic devices.
2. Polishing of natural and restored teeth using air polishers.
3. Performing a clinical examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets or other abnormal conditions for further evaluation and diagnosis by the dentist.
4. Subgingival irrigation or subgingival application of topical Schedule VI medicinal agents.
5. Duties appropriate to the education and experience of the dental hygienist and the practice of the supervising dentist, with the exception of those listed in subsection A of this section and those listed as nondelegable in 18VAC60-20-190.

SPECIAL BULLETIN

September 30, 2002 *

Clarification of General Supervision

The Board has received numerous questions and statement of concern about the Emergency Regulations implementing General Supervision of Dental Hygienists. The questions cover diverse subjects ranging from billing to the procedures that may be delegated to the requirements for a prescription to the proximity of and the required relationship with the dentist. The Board its September 20, 2002 meeting reviewed these questions from dental hygienists and interested organizations.

The Board intended through the promulgation of the emergency regulations to enable dentists to order certain limited hygiene treatment to be performed by a dental hygienist when the treating dentist is not present. The Board is interpreting the emergency regulations consistent with this intent as reflected in the answers to the following questions and comments. The following questions are stated exactly as they were submitted in the correspondence received by the Board.

Q. "Is placement of sub gingival medicament (i.e. arestin, periochip) permissible?"

A. No, a dental hygienist practicing under general supervision may not place sub gingival medicaments. The Virginia Drug Control Act requires that the administration of Schedule VI topical drugs be under the direction and supervision of a dentist.

Q. "Are x-rays permitted to be taken if the dentist prescribes?"

A. Yes, a dental hygienist practicing under general supervision may take x-rays as ordered by the treating dentist.

Q. "Must the prescription include if x-rays are to be taken? If so, can the prescription state "necessary x-rays?"

A. The dentist may order x-rays to be taken under supervision. The x-rays to be taken should be specified in the order.

Q. "Is placement of a 15% hydrogen peroxide gel and phst-activation component permissible under general supervision or direct supervision?"

A. Placement of these medications is not permitted under general supervision but is permitted under direct supervision. Schedule VI topical drugs may only be administered by a dental hygienist under the direction and supervision of a dentist.

Q. "A question has come up about free clinics and community health centers and how the low [translated the mean the Emergency Regulations] should be interpreted in those situations."

A. A dentist practicing in a free clinic, volunteer clinic or a public health program may issue an order for hygiene treatment under general supervision. Any dental hygienist practicing in the free clinic, volunteer program or public health program may fill the order.

Q. "The requirement that the patient must be seen by a dentist for the initial evaluation makes the timely provision of care in free clinics and community health programs nearly impossible."

A. The statute providing for general supervision requires that a dentist complete an evaluation and prescribe authorized services. Dental hygienists may only provide treatment when a dentist has previously evaluated the patient and ordered hygiene treatment to be provided under general supervision.

Q. "We are requesting clarification on the dentist-hygienist supervision ratio under general supervision."

A. A dentist may not have more than two dental hygienists working under direction or general supervision at one and the same time in his private office/practice. If the dentist is present in the office then the hygienists providing treatment, must be under supervision. If the dentist has planned to be out of the office then he may have up to two hygienists working under general supervision. He may, through issuance of a written order for hygiene treatment authorized any dental hygienist to treat patients in a free clinic, volunteer program or public health program under general supervision.

Q. "Both dentists and hygienists have raised questions about the application if topical anesthesia under general supervision. We contend that §54.1-3408 covers both the direction and general supervision of dental hygienists."

A. The Virginia Drug Control Act requires that Schedule VI topical drugs may only he administered by a dental hygienist under the direction and supervision of a dentist.

Q. "18 VAC 60-20-220.B.3 states a clinical exam can be performed under general supervision. Would this exam be considered equivalent to an ADA CDT code DOO120 Periodic Oral Evaluation?"

A. The Board does not directly regulate billing practices. The Board's involvement in billing practices is triggered by receipt of a complaint that alleges false, deceptive or misleading billing activities that may constitute fraud. Patients and third party payers can file such complaints. The dentist is responsible for understanding and using codes such as the one referenced to accurately represent the service rendered.

Q. "With regard to prescribed or prescription is there a new written standard form of communication that is an ASA accepted legal document? It sounds like a patient can now be transposed to have the recommended treatment performed in any dental office, which we know to be true, but what of differing opinions?"

A. No, there is no standard form or format. The order may be entered in writing in the treatment notes for the patient or may be written on a separate document and included in the patient record. The order must be followed exactly. The dental hygienist or another dentist cannot alter it.

Q. "With regard to consent of the hygienist, is the consent to be implied, written or oral, for each patient, before, during, or after the hiring of such hygienist employee? What if the hygienist refuses or denies giving the consent?"

A. The agreement of the dental hygienist to practice under general supervision should be in writing and should be maintained on file by the dentist. The consent can be addressed before, during or after hiring at the discretion of the dentist and the dental hygienist. The dental hygienist's consent can be given generally and does not need to be documented in each patient's record. It is the dental hygienist's decision whether or not the consent to practice under general supervision.

Q. "With regard to informing the patient/legal guardian prior to the appointment, in a sense obtaining informed consent, why would a dentist potentially undermine his/her own authority in the event of miscommunication either intended or not, by an employee hygienist or other staff member, thereby risking compromising the integrity of the doctor-patient relationship?"

A. There is nothing in the regulations that would require a dentist to act in the manner you question. General supervision must be planned in advance of a patient visit based on the dentist's examination of the patient. The dentist may inform the patient of the proposal for general supervision or may delegate this responsibility to a staff member. A dentist is expected to establish the protocols to be used in his office in order to fully comply with the regulations for general supervision.

Q. "With regard to emergency procedures, in the event of a life-threatening emergency, why would a dentist place him/herself in a risk exposure situation by placing the safety of the practice in the hands of a potentially lesser-trained employee? What are the basic emergency training guidelines or minimal standard requirements?"

A. The dentist is not obligated to have dental hygienists practicing under general supervision. The dentist needs to decide whether treatment under direction or general supervision is appropriate for each patient. He must provide services under direction if necessary to meet the individual needs of the patient. The Board has not established guidelines or minimal standards for the required emergency procedures for general supervision. The Board charges the dentist with responsibility for planning for the management of emergencies in his absence.

Q. "Is the dentist permitted to charge an examination fee to patients if the hygienist performs the examination?"

A. The Board does not directly regulate billing practices. The Board's involvement in billing practices is triggered by receipt of a complaint that alleges false, deceptive or misleading billing activities that may be fraudulent. A dentist is free to charge for an examination to the extent that he has advised the patient about the nature of the examination and its costs. The willingness of third party payers to cover such costs should also be addressed with the patient and the payer.

Q. "May the doctor leave the office building after completing the initial examination and then assign the remaining procedures to the dental hygienists to do in his or her absence?"

A. Yes, provided the patient is properly noticed and does not object and there is an order for treatment under general supervision.

Q. "Are hygienist allowed to take alginate impressions in the dentist's absence?"

A. Yes, provided the order includes this services.

Q. "Are hygienists allowed to deliver beaching trays to patients in the absence of the dentist?"

A. Yes, but they may not deliver bleaching agents.

Q. "Do the new regulations have any effect on billing procedures (i.e. should the dentist bill the patients and the insurance agency in the same manner as previously done?"

A. The Board does not directly regulate billing practices. The Board's involvement in billing practices is triggered by receipt of a complaint that alleges false, deceptive or misleading billing activities that may be fraudulent. Patients and third party payers can file such complaints. The willingness of third party payers to cover such costs should be addressed with the payers.

Q. "The committee (VDA Dental Practice Regulations Committee) would like to request a sample statement to patients informing them of the implementation of general supervision of hygienists."

A. The Board declines to provide a sample statement. The Board charges the dentist with responsibility for meeting the requirements set forth in the regulations as he deems appropriate for his patients and his practice.

Q. "I ask for a point of clarification regarding 18 VAC 60-20-200. Does this mean that a dentist can have 4 hygienists working simultaneously? Two hygienists working under his direction + being examined and 2 hygienists working under general supervision."

A. No, a dentist may not have 4 hygienists working simultaneously. The dentist should only employ general supervision during planned absences. A dentist may only have 2 hygienists working in his office practice at one and the same time.

Questions and comments regarding the information in this bulletin should be directed to the executive director of the Board, Sandra K. Reen at (804) 662-9906 or 6603 West Broad Street, 5th Floor, Richmond, Virginia, 23230-1712 or sandra.reen@dhp.state.va.us.

This bulletin is posted on the Board of Dentistry web page at http://www.dhp.state.va.us/dentistry/default.htm.

*Minor editorial changes to correct spelling and to remove redundant language, etc. have been made to the Special Bulletin during the editing process for this publication.

Agenda Item: Changing the Education Requirement for Dental Licensure

Dr. Wyman is requesting discussion on amending this regulation.

18VAC60-20-60. Educational requirements for dentists and dental hygienists.

A. Dental licensure. An applicant for dental licensure shall be a graduate and a holder of a diploma or a certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association, which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program in any other specialty.

B. Dental hygiene licensure. An applicant for dental hygiene licensure shall have graduated from or have been issued a certificate by a program of dental hygiene accredited by the Commission on Dental Accreditation of the American Dental Association.

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, April 29, 2014 9:49 AM
To: Bruce Wyman
Subject: RE: Item for the June Board meeting

Importance: Low

Hi Bruce:
I will see if I can find any available info on other states' licensure requirements to include in the agenda package. It would be helpful for you to address what prompts your concerns and the sources of information you are relying on regarding the quality of the applicants.
Smile,
Sandy

From: Bruce Wyman [mailto:bswyman@gmail.com]
Sent: Monday, April 28, 2014 10:11 AM
To: Reen, Sandra (DHP)
Subject: Re: Item for the June Board meeting

II have had individual discussions with several board members and we all agree that one year is not enough to require, given the quality of some of the people that are being licensed with only one year of postgraduate training in United States. I do not have any written material.

Do you have any way of researching other states requirements in this matter?

Bruce Wyman
Sent from my iPhone

On Apr 28, 2014, at 9:31 AM, "Reen, Sandra (DHP)" <Sandra.Reen@DHP.VIRGINIA.GOV> wrote:

> Hi Bruce:
> I will include this on the Board's June 13 meeting agenda. Please send me any information you want included in the agenda package by May 20.
> Smile,
> Sandy
>
> ---
>
> **From:** Bruce Wyman [mailto:bswyman@gmail.com]
> **Sent:** Sunday, April 27, 2014 4:21 PM
> **To:** Reen, Sandra (DHP)
> **Subject:** Item for the June Board meeting
>
> Sandy,
> I know I had something similar to this was on a recent meeting agenda and then I dropped it, but I would like to again place on the agenda a requirement that any dentist who has a dental degree from anywhere other than the US or Canada be required to have at least 2 years of postgraduate studies in the US rather than the current 1 year requirement.
>
> Thanks again and I will see you on Friday when I will be attending the Regulatory Comm. Meeting.
>
> Bruce Wyman

Agenda Item: Electronic Dental Records

Dr. Rizkalla is requesting Board discussion because he is concerned that computerized data entry can impact the quality and safety of patient care. The introduction of the Electronic Medical Record (EMR) and the continuous software innovations can have unintended consequences including changes in staff roles, responsibilities and patient outcomes.

It is proposed that we investigate the possible role of the Board of Dentistry in safeguarding patient care.

§ 54.1-2403.2. Record storage.

A. Health records, as defined in § 32.1-127.1:03, may be stored by computerized or other electronic process or microfilm, or other photographic, mechanical, or chemical process; however, the stored record shall identify the location of any documents or information that could not be so technologically stored. If the technological storage process creates an unalterable record, a health care provider licensed, certified, registered or issued a multistate licensure privilege by a health regulatory board within the Department shall not be required to maintain paper copies of health records that have been stored by computerized or other electronic process, microfilm, or other photographic, mechanical, or chemical process. Upon completing such technological storage, paper copies of health records may be destroyed in a manner that preserves the patient's confidentiality. However, any documents or information that could not be so technologically stored shall be preserved.

B. Notwithstanding the authority given in this section to store health records in the form of microfilm, prescription dispensing records maintained in or on behalf of any pharmacy registered or permitted in Virginia shall only be stored in compliance with §§ 54.1-3410, 54.1-3411, and 54.1-3412.

(1994, c. 390; 1998, c. 470; 2004, c. 49; 2012, c. 336.)

Disciplinary Board Report for June 13, 2014

Today's report reviews the 2014 calendar year case activity then addresses the Board's disciplinary case actions for the third quarter of fiscal year 2014 which includes the dates of January 1, 2014 through March 31, 2014.

Calendar Year 2014

The table below includes all cases that have received Board action since January 1, 2014 through May 28, 2014.

Calendar 2014	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan	36	21	7	28
Feb	37	14	5	19
March	72	29	8	37
April	50	5	4	9
May 28th	21	11	9	20
Totals	**216**	**80**	**33**	**113**

Q3 FY 2014

For the third quarter, the Board received a total of 84 patient care cases. The Board closed a total of 65 patient care cases for a 77% clearance rate, which is down from 127% from last quarter. The current pending caseload older than 250 days is 25%, which is unchanged from the second quarter. In the third quarter of 2014, 74% of the patient care cases were closed within 250 days. The Board did not meet the clearance rate goals for the Agency's Key Performance Measures[1] for the third quarter of 2014.

Board staff believes there are multiple reasons for the decline in our numbers in the third quarter. A few of those items are listed below:

- Increased number of summary actions that require immediate action;
- Loss of personnel in other divisions of the agency;
- Board members are not returning cases within the 15 day timeline, often taking a month or more to make a decision;
- Board staff is taking a significant amount of time reviewing completed probable cause sheets to determine if the evidence supports the violations. For example:

[1] The Agency's Key Performance Measures.

- We will achieve a 100% clearance rate of allegations of misconduct by the end of FY 2009 and maintain 100% through the end of FY 2010.
- We will ensure that, by the end of FY 2010, no more than 25% of all open patient care cases are older than 250 business days.
- We will investigate and process 90% of patient care cases within 250 work days.

- Board members are citing a Respondent for substandard treatment they did not perform
- Board members are citing Respondents for failure to document when the patient record notes the information, maybe in a note from a previous appointment or often in the corresponding treatment date, just on another page in the record

- Board staff is taking a significant amount of time reviewing sanctioning. Board members are "over-sanctioning." For example, requesting an informal conference when a confidential consent agreement is appropriate; and
- Board members are writing down their thought process only and not including the final violations on the probable cause review forms.

We must be diligent about reviewing the entire file, filling out the probable cause review forms accurately and completely and remember if you have a question, call or email prior to completing your review and we can help!

License Suspensions

Between February 23, 2014 and May 28, 2014, the Board summarily suspended the license of two dentists, two hygienists and summarily restricted the license of one dentist.

Board Sanctions

It has come to the Board's attention recently that under §54.1-2522 of the Code of Virginia, dentists are not required to report to the Prescription Monitoring Program the dispensing of Schedule II-IV substances in their offices to patients in a bona fide medical emergency or when pharmaceutical services are not available. However, the Board does appear to have the ability to require such reporting in an individual Board Order.

Board staff would like some guidance on whether the Board would like to add as a possible sanction in Board orders, a requirement for Respondents to report dispensing of Schedule II-IV substances in their offices when the facts of a case warrant such a sanction.

There have been concerns raised by Respondents and/or their attorneys that the Board's practice of placing Respondents on indefinite probation with the terms of only the completion of continuing education, passing the Board's Dental Law Exam, or unannounced inspections is creating a problem with malpractice insurance. The concern is that the above terms are not a "restriction" on the Respondent's license or practice. Other boards within DHP attach indefinite probation or probation to terms such as completion of a certain number of years in active practice, restrictions on prescribing drugs, restrictions on performing certain procedures (may be tied with the completion of continuing education), work-site monitoring, submission of therapy reports, or compliance with the Health Practitioners' Monitoring Program, which are more consistent with a restriction on the Respondent's license or ability to practice.

Board staff is requesting guidance on whether the Board would like to continue its practice of placing Respondents on indefinite probation when the terms and conditions consist of completing continuing education courses, passing the Board's Dental Law Exam, or unannounced inspections.

Agenda Item: Recommendation on Adoption of the Inspection Form for Permit Holder Office Inspections

The Regulatory/Legislative Committee recommended adoption of the inspection form with the addition of inspecting for emergency preparedness.

Virginia Board of Dentistry Dental Inspection Form Date Hours Case#
Commonwealth of Virginia
Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-367-4538

PERMIT HOLDER INSPECTIONS DISCUSSION DRAFT

TYPE OF INSPECTION

_____COMPLAINT INVESTIGATION _____COMPLIANCE _____OMS COSMETIC PROCEDURES AUDIT

_____PERIODIC PERMIT HOLDER Permit type: _____ Conscious/Moderate ____Deep Sedation/General Anesthesia
Permit#: _____ Exp. Date: _____ Facility #: _____

NAME OF SUBJECT DENTIST LICENSE #

PRACTICE NAME SPECIALTY PRACTICE

STREET ADDRESS CITY STATE ZIP CURRENT ADDRESS OF RECORD

PHONE: FAX: HOURS OF OPERATION:

STAFF: (Identify dentists, hygienists, assistants, and general office staff)	POSITION	LICENSE	EXP. DATE	Assists in Sedation GA

C NC NA	18VAC60-20-200	Utilization of Dental Hygienists and Dental Assistants II No more than 4 dental hygienists or dental assistants II in any combination practicing under direction at the same time.
C NC NA	18VAC60-20-210	If Dental Hygienists practice under general supervision determine if: Y N Written orders are in the patient record. Y N The services on the original order are to be rendered within a specific time period not to exceed 10 months. Y N The dental hygienist has consented in writing to providing services under general supervision. See personnel record. Y N The patient is informed before the appointment that he will be treated under general supervision. See patient record. Y N Written basic emergency procedures are established and the hygienist is capable of implementing those procedures. See the procedures. Ask the hygienist about preparation and training. If any of the requirements above are not met obtain a copy of one patient record to support an allegation of non-compliance.

POSTING OF CURRENT LICENSES, CERTIFICATES, AND REGISTRATIONS

C NC NA	54.1-2720	Name of every dentist practicing in this office is displayed at the entrance of the office.
C NC NA	54.1.2721	Dental Licenses are posted in plain view of patients.
C NC NA	54.1-2727	Dental Hygiene Licenses are posted in plain view of patients.
C NC NA	18VAC60-20-16	Dental Assistant II Registrations are posted in plain view of patients.
C NC NA	18VAC60-20-195	Radiation Certificate is posted for each person who exposes dental x-ray and is not otherwise licensed.
C NC NA	12VAC5-481-370.A (1) B	Department of Health's certification of x-ray machine is current and posted near the x-ray machine.
C NC NA	18VAC60-20-110(D)	Deep Sedation/General Anesthesia Permit or AAOMS certificate AND DEA registration are posted in plain view of patients.
C NC NA	18VAC60-20-120(G)	Conscious/Moderate Sedation Permit or AAOMS certificate AND DEA registration is posted in plain view of patients.

EDUCATION		
C NC	Check which option applies: ____18VAC60-20-50 Dentists must hold current certification in basic life support or cardiopulmonary resuscitation with hands-on airway training for healthcare providers. Current training in advanced resuscitation techniques with hands on simulated airway training for health care providers meets this requirement. OR ____18VAC60-20-110(C)(2) and 18VAC60-20-120(F) Dentists who administers conscious/moderate sedation, deep sedation or general anesthesia must hold current certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers including basic electrocardiographic interpretation	
C NC NA	18VAC60-20-50	Dental hygienists must hold current certification of completion of a hands-on course in basic cardiopulmonary resuscitation for health care providers
C NC NA	18VAC60-20-50	Dental assistants II must hold current certification of completion of a hands-on course in basic cardiopulmonary resuscitation for health care providers
C NC NA	18VAC60-20-107(I)	Dentists who administers conscious/moderate sedation, deep sedation or general anesthesia has completed at least four hours of continuing education directly related to such administration within the past 2 years
C NC NA	18VAC60-20-107(I)	Dental hygienists who monitor patients under conscious/moderate sedation, deep sedation or general anesthesia has completed at least four hours of continuing education directly related to such monitoring within the past 2 years
C NC NA	18VAC60-20-107 (G)(2)	Written basic emergency procedures are readily accessible when any level of sedation or general anesthesia is administered
C NC NA	18VAC60-20-107(G)(2)	Record of staff training to carry out emergency procedures when any level of sedation or general anesthesia is administered NOTE THE MOST RECENT DATE OF TRAINING:_____
C NC NA	18VAC60-20-135	Personnel, i.e. dental assistants, who assist in the administration and monitoring of conscious/moderate sedation or deep sedation and general anesthesia, must hold current certification in basic resuscitation techniques with hands-on airway training for health care providers.

RECORDKEEPING 18VAC60-20-15 and 18VAC60-20-107

Obtain Patient Records for content and compliance review by the Board as follows:

- For inspections addressing Complaint Investigations related to treatment or billing practices obtain the treatment records of all patients identified in the complaint.
- For inspections addressing Complaint Investigations related to unsafe/unsanitary conditions or practices obtain the source's patient record and two (2) additional patient records of patients who were recently treated. Review the patient schedule and randomly select the patients. Interview the source and these two (2) patients about their experience/observations.
- For sedation and anesthesia Permit Holders obtain two (2) patient records of patients who were recently treated under sedation or anesthesia. Review the patient schedule and randomly select the patients.
- Inspect each record collected to determine if:
  - ___ All handwritten and electronic documents and evidence are legible and complete
  - ___ Both sides of 2 sided documents are included
  - ___ Xrays, digital images and photographs are labeled with patient's name, date taken and content of the image including teeth numbers
  - ___ Patient and insurance billing records/correspondence are included
  - ___ Laboratory work orders are included
  - ___ Computerized prescriptions are included
  - ___ Periodontal charting is included
  - ___ CDs will open and content is accessible and legible

ENVIRONMENTAL CONDITIONS §54.1-2706(5) and/or §54.1-2706(11)
Reference the CDC Guidelines for Infection Control in Dental Health-Care Settings

All sections of the facility appear neat and clean without any safety hazards Yes No

Observed equipment with broken or missing parts; oil/grease on any equipment; or dirty suction hoses, etc. Yes No
If yes, describe and photograph:

Describe sterilization process to include equipment used (should include heat and/or spore indicators.)

Who processes spore indicators? Obtain names and positions held.
Verify that results are maintained. Yes No

What is office protocol when sterilization equipment indicates equipment is not working properly?

Is the protocol available to staff in a print or electronic document? Yes No

How are sterilized instruments maintained?

How are clinical surfaces disinfected and sanitized?

Frequency?

Solutions used?

Are sharps containers available? Yes No

Verify that there is a current contract, bill or receipt to document service for disposing of sharps/biohazard waste. Yes No

Appropriate personal protective equipment including gloves, face protection, eye protection and lead aprons are in stock. Yes No

Safe and accessible building exits in case of fire or other emergency were observed. Yes No

DRUG SECURITY, INVENTORY AND RECORDS §54.1-2706(5), §54.1-2706(11) and/or §54.1-2706(15)

The dentist only maintains Sch VI controlled drugs. Yes No

If yes, answer the first question below then skip to the ANESTHESIA, SEDATION AND ANALGESIA section.

If the dentist maintains any Sch II –V controlled drugs complete this section.

C NC		Expired drugs are stored separate from the working stock of drugs until properly disposed
C NC	CFR 1301.75 (b)	Sch II-V controlled substances are stored in a securely locked, substantially constructed cabinet
C NC	CFR 1304.04 (f)	Inventories and records of Sch II controlled substances are maintained separately from all other records and are readily retrievable
C NC	CFR 1304.04 (f)	Inventories and records of Sch III-V controlled substances are maintained either separately from all other records or in such a form that the information is readily retrievable
C NC		Records of Sch II-V controlled substances are maintained in chronological order
C NC	54.1- 3404. F	Required records are maintained completely and accurately for two years from the date of the transaction
C NC	54.1-3404. C	Records of receipt include the actual date of receipt, name and address of the person from whom received, and the name, strength and quantity of drug received
C NC	54,1-3404. D	Records of drugs sold, administered, dispensed or disposed of include the date of the transaction, name of patient, drug name, quantity of drug, and signature of person making the transaction
C NC	54.1-3404. A& B	Biennial inventory of Sch II-V drugs available was taken on a date within two years of the previous biennial inventory
C NC	54.1-3404. A & B	Biennial inventory is dated and indicates whether it was taken at the opening or close of business. Specify.
C NC NA	54.1-3404. E	Theft or unusual loss of drugs in Sch II-V is reported to the board of Pharmacy and an inventory taken if the registrant is unable to determine the exact kind and quantity of drug loss

ANESTHESIA, SEDATION AND ANALGESIA

Dentist only administers local anesthesia? Yes No If yes, stop here. The remaining sections do not apply.

Dentist only administers minimal sedation? Yes No If yes, complete the question on emergency procedures and only the first columns in the next two sections.

Dentist has a conscious/moderate sedation permit? Yes No If yes, complete the question on emergency procedures and only the third columns in the next two sections.

Dentist has a deep sedation and general anesthesia permit? Yes No If yes, complete the question on emergency procedures and only the second columns in the next two sections.

Note here any descriptions provided on the administration practices followed and/or on the level of effect and condition of patients to help the Board assess the level of administration being administered:

EQUIPMENT REQUIREMENTS FOR ANESTHESIA, SEDATION AND ANALGESIA

18VAC60-20-108 (B) A dentist who administers MINIMAL SEDATION (anxiolysis or inhalation analgesia) shall maintain the following operational equipment and be trained in its use	18VAC60-20-110(F) A dentist who administers DEEP SEDATION/GENERAL ANESTHESIA shall maintain the following operational equipment in sizes for adults or children as appropriate for the patient being treated	18VAC60-20-120(I) A dentist who administers CONSCIOUS/MODERATE SEDATION shall maintain the following operational equipment in sizes for adults or children as appropriate for the patient being treated
C NC Blood Pressure Monitoring	C NC Full face mask	C NC Full face masks
C NC Positive Pressure Oxygen	C NC Oral and Nasopharyngeal airway management adjuncts	C NC Oral and Nasopharyngeal airway management adjuncts
C NC Mechanical (hand) respiratory bag	C NC ET tubes with appropriate connectors or airway adjuncts such as a laryngeal mask	C NC ET tubes with appropriate connectors or airway adjuncts such as a laryngeal mask
	C NC Laryngoscope with reserve batteries and bulbs and appropriately sized blades	C NC Pulse Oximetry and BP Monitoring
	C NC Source of delivery of oxygen under controlled positive pressure	C NC Pharmacological antagonist agents unexpired
	C NC Mechanical (hand) respiratory bag	C NC Positive Pressure Oxygen
	C NC Pulse Oximetry and BP monitoring	C NC Emergency drugs for resuscitation
	C NC Emergency drugs for resuscitation	C NC Mechanical (hand) resp bag
	C NC EKG/ Temp monitoring equipment	C NC Suction apparatus
	C NC Pharmacological antagonist agents	C NC Throat Pack
	C NC External defibrillator (manual or automatic)	C NC External defibrillator (manual or automatic)
	C NC An end-Tidal CO_2 monitor for intubated patients	C NC Precordial or pretracheal sthethoscope
	C NC Suction apparatus	C NC Temp measuring device
	C NC Throat Pack	C NC Electrocardiographic monitor
	C NC Precordial or pretracheal sthethoscope	

STAFFING REQUIREMENTS FOR ANESTHESIA, SEDATION, & ANALGESIA

Y N Dentist has written basic emergency procedures and staff is trained to carry out the procedures. See the procedures. Ask staff about preparation and training.

18VAC60-20-108	18VAC60-20-110	18VAC60-20-120
A dentist who administers MINIMAL SEDATION by only using nitrous oxide/oxygen assures that: C NC NA The person who administers the nitrous oxide/oxygen or another dental staff member is always present with the patient until discharged. A dentist who administers MINIMAL SEDATION by anxiolysis with or without nitrous oxide/oxygen uses a: C NC NA Treatment team which includes the dentist & a second person to assist, monitor & observe the patient until discharged.	A dentist who administers DEEP SEDATION/GENERAL ANESTHESIA uses a: C NC Treatment team which includes the operating dentist, a second person to monitor & observe the patient, & a third person to assist the operating dentist	A dentist who administers CONSCIOUS/MODERATE SEDATION uses a: C NC Treatment team which includes the operating dentist & a second person to assist, monitor, & observe the patient.

ORAL AND MAXILLOFACIAL SURGEONS

Y N 18VAC60-20-250 Has Current Board Registration
Y N 18VAC60-20-260 Has updated practitioner profile. Attach Profile.
Y N 18VAC60-20-290 Performs cosmetic procedures and is certified by the Board according to §54.1-2709.

Please check all certifications for cosmetic procedures this licensee holds:

A. [ ] Rhinoplasty/similar procedures
B. [ ] Blepharoplasty/similar procedures
C. [ ] Rhytidectomy/similar procedures
D. [ ] Submental liposuction/similar procedures
E. [ ] Browlift/either open or endoscopic technique/similar procedures
F. [ ] Otoplasty/similar procedures
G. [ ] Laser resurfacing or dermabrasion/similar procedures
H. [ ] Platysmal muscle plication/similar procedures

Compliant (C) Non Compliant (NC) Not Applicable (NA)

Additional Inspection Observations and Notes

Signature of Inspector Date Signature of Licensee Date

BOARD OF DENTISTRY
PROPOSED 2015 CALENDAR

JANUARY

S	M	T	W	T	F	S	
				[redacted]	2	3	
4	5	6	7	8	9	10	SCC-C
11	12	13	14	15	[redacted]	17	
18	[redacted]	20	21	22	23	24	SCC-A
25	26	27	28	29	30	31	SCC-B

FEBRUARY

S	M	T	W	T	F	S	
1	2	3	4	5	6	7	
8	9	10	11	12	13	14	RESERVE
15	[redacted]	17	18	19	20	21	SCC-C
22	23	24	25	26	27	28	

MARCH

S	M	T	W	T	F	S	
1	2	3	4	5	[redacted]	7	SCC-A
8	9	10	11	[redacted]	[redacted]	14	Formals/Board
15	16	17	18	19	20	21	SCC-B
22	23	24	25	26	27	28	
29	30	31					

APRIL

S	M	T	W	T	F	S	
			1	2	3	4	SCC-C
5	6	7	8	9	10	11	
12	13	14	15	16	17	18	SCC-A
19	20	21	22	23	24	25	
26	27	28	29	30			

MAY

S	M	T	W	T	F	S	
					[redacted]	2	SCC-B
3	4	5	6	7	8	9	RESERVE
10	11	12	13	14	15	16	SCC-C
17	18	19	20	21	22	23	
24	[redacted]	26	27	28	29	30	
31							

JUNE

S	M	T	W	T	F	S	
	1	2	3	4	[redacted]	6	SCC-A
7	8	9	10	[redacted]	[redacted]	13	Formals/Board
14	15	16	17	18	19	20	SCC-B
21	22	23	24	25	26	27	SCC-C
28	29	30					

JULY

S	M	T	W	T	F	S	
			1	2	[redacted]	4	
5	6	7	8	9	10	11	
12	13	14	15	16	17	18	SCC-A
19	20	21	22	23	24	25	
26	27	28	29	30	31		SCC-B

AUGUST

S	M	T	W	T	F	S	
						1	
2	3	4	5	6	7	8	SCC-C
9	10	11	12	13	14	15	
16	17	18	19	20	21	22	
23	24	25	26	27	28	29	SCC-A
30	31						

SEPTEMBER

S	M	T	W	T	F	S	
		1	2	3	4	5	
6	[redacted]	8	9	10	11	12	SCC-B
13	14	15	16	[redacted]	[redacted]	19	Formals/Board
20	21	22	23	24	25	26	SCC-C
27	28	29	30				

OCTOBER

S	M	T	W	T	F	S	
				1	[redacted]	3	SCC-A
4	5	6	7	8	9	10	
11	[redacted]	13	14	15	16	17	RESERVE
18	19	20	21	22	23	24	SCC-B
25	26	27	28	29	30	31	

NOVEMBER

S	M	T	W	T	F	S	
1	2	3	4	5	6	7	SCC-C
8	9	10	[redacted]	12	13	14	
15	16	17	18	19	20	21	SCC-A
22	23	24	[redacted]			28	
29	30						

DECEMBER

S	M	T	W	T	F	S	
		1	2	3	4	5	SCC-B
6	7	8	9	[redacted]	[redacted]	12	Formals/Board
13	14	15	16	17	18	19	
20	21	22	23	[redacted]		26	
27	28	29	30	31			

FORMAL HEARINGS	BOARD MEETINGS	RESERVE DAYS	SCC – A	SCC – B and Credentials	SCC – C
March 12	March 13	Feb 13	January 23	January 30	January 9
June 11	June 12	May 8	March 6	March 20	February 20
September 17	September 18	Oct 16	April 17	May 1	April 3
December 10	December 11		June 5	June 19	May 15
[redacted]			July 17	July 31	June 26
			August 28	September 11	August 8
			October 2	October 23	September 25
			November 20	December 4	November 6

Adopted: